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## MONTHLY PROGRESS REPORT ★ SECTION

## HEALTH

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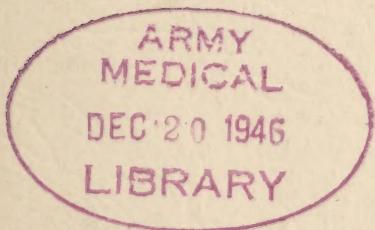
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# HEALTH

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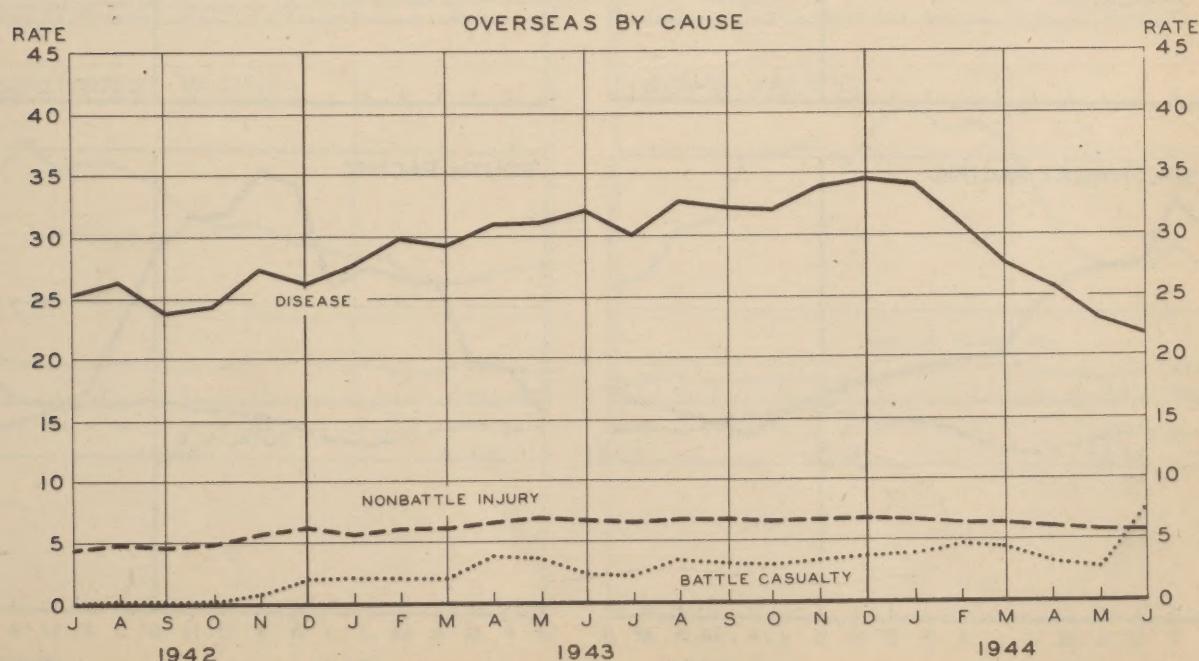
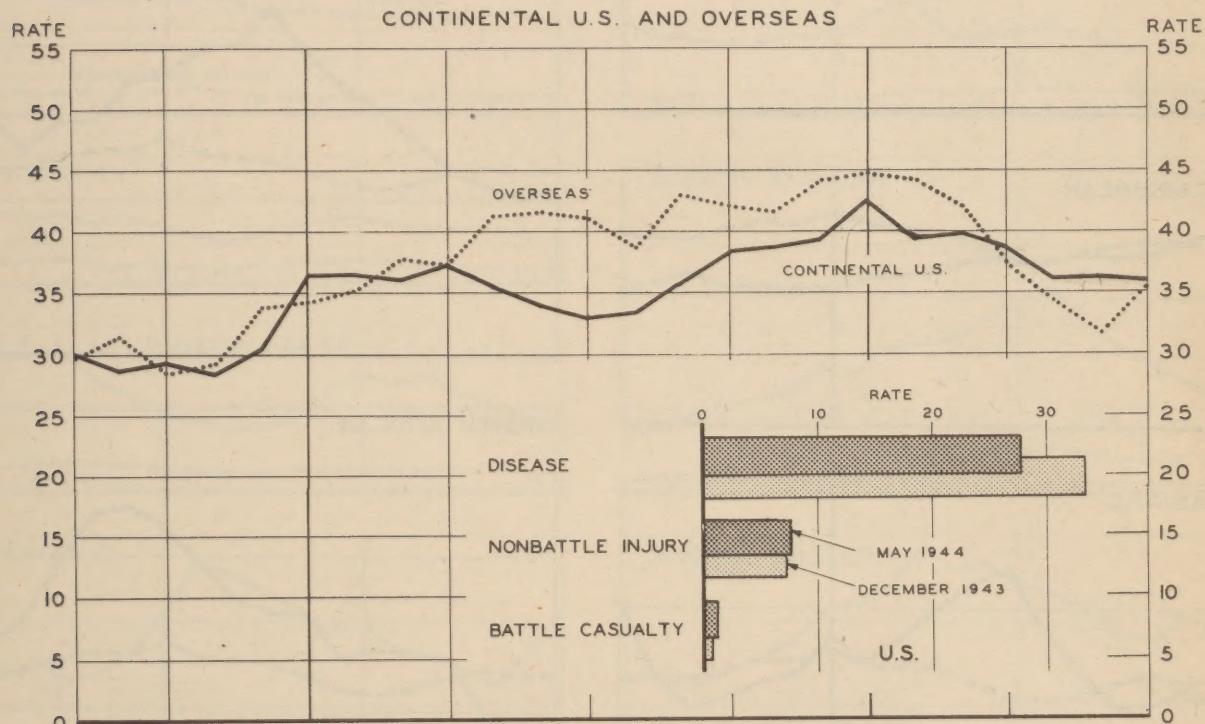
## DISEASE AND INJURY

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## NONEFFECTIVE RATES, U. S. AND OVERSEAS

During June the average daily noneffective rate changed only slightly for troops in the Continental U. S., but advanced sharply for troops overseas, according to preliminary telegraphic information. The rate for troops in the U. S. is no longer a true measure of health conditions in the U. S., however, because the admission rate has been declining steadily since December without the expected decline in noneffectiveness. This is attributable to the hospitalization of evacuees, who contribute about 6 or more noneffectives per 1,000 U. S. strength, and to patients left behind by units moving overseas. Corrected for the influence of these two factors, the U. S. rate is more nearly 27 to 30 noneffectives per thousand men per day. Correspondingly, the overseas rate of 35 for June would be even higher if evacuees in the U. S. were charged against the overseas strength. The overseas rate rose abruptly in June under the influence of the battle activity in the European and North African theaters.

## NONEFFECTIVES PER THOUSAND MEN PER DAY



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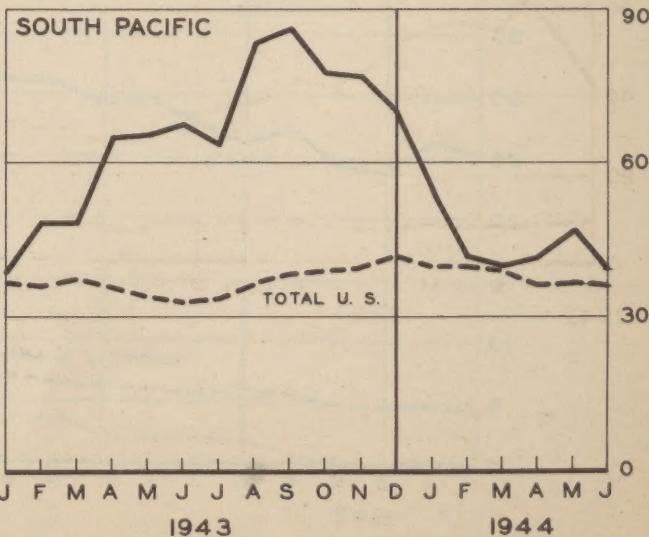
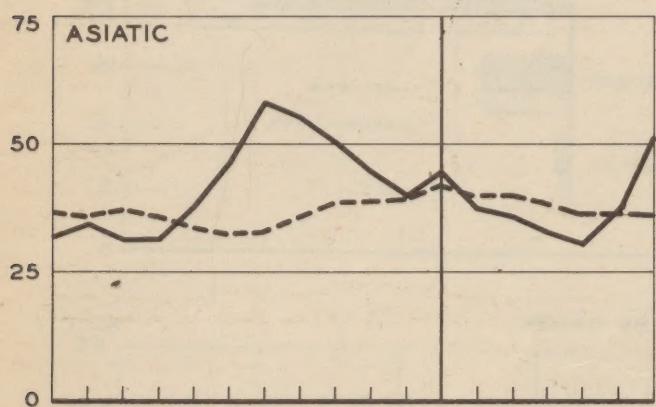
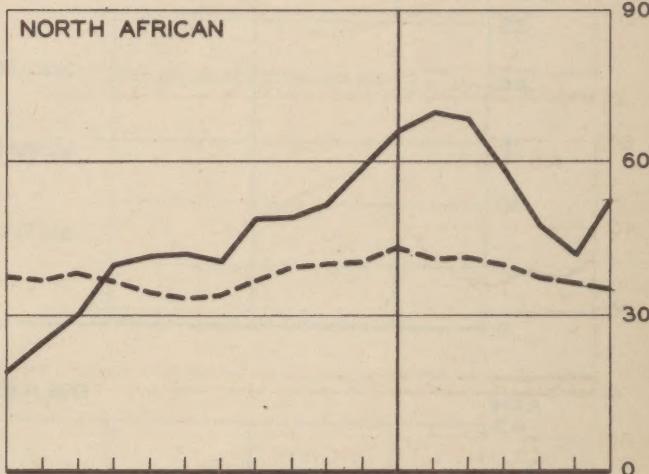
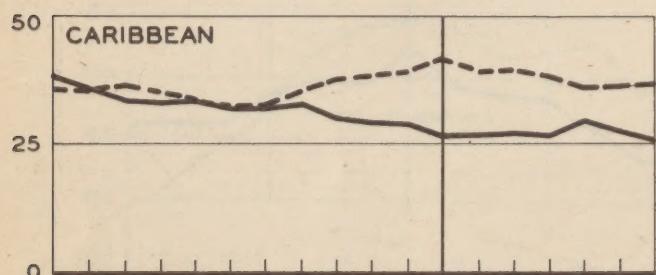
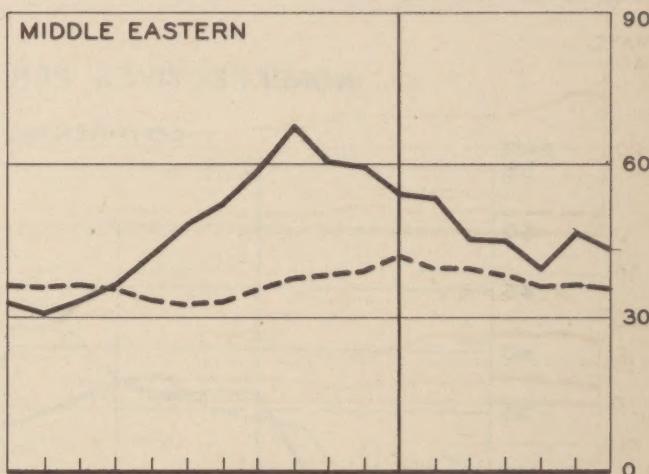
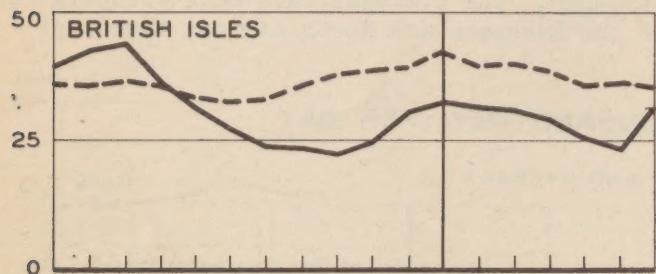
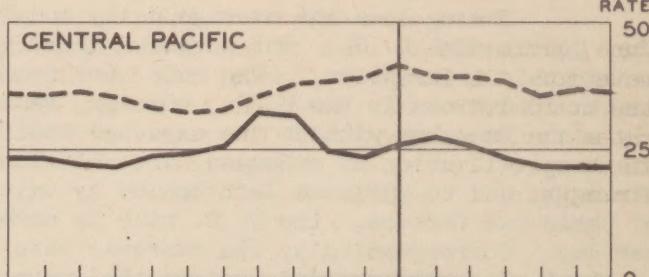
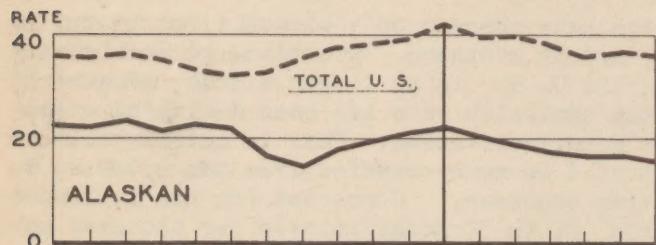
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## DISEASE AND INJURY

**NONEFFECTIVES PER THOUSAND MEN PER DAY**  
**ALL CAUSES, OVERSEAS COMMANDS**



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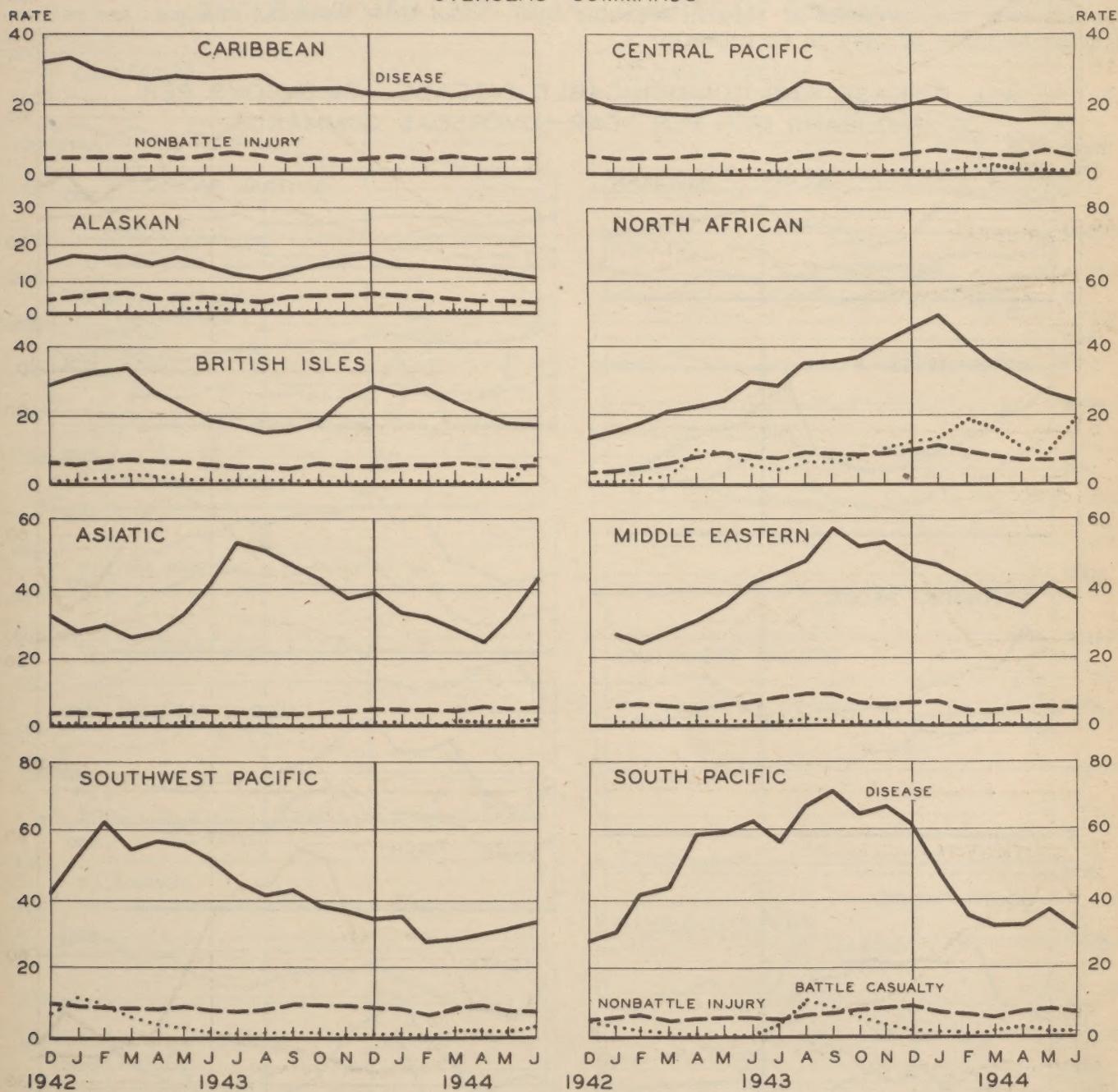
## DISEASE AND INJURY

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### NONEFFECTIVE RATES OVERSEAS

There were important changes in the noneffective rates for overseas theaters during June, primarily because of the increasing importance of the battle casualty components of the rate for the European Theater and for North Africa. The panels on the opposite page portray the total rates for each theater, and those below give the major components of the total rates for each theater. The rates for the British Isles are provisional estimates prepared in advance of complete telegraphic information. The reports from the Central Pacific may be incomplete for battle casualties.

NONEFFECTIVES PER THOUSAND MEN PER DAY  
OVERSEAS COMMANDS



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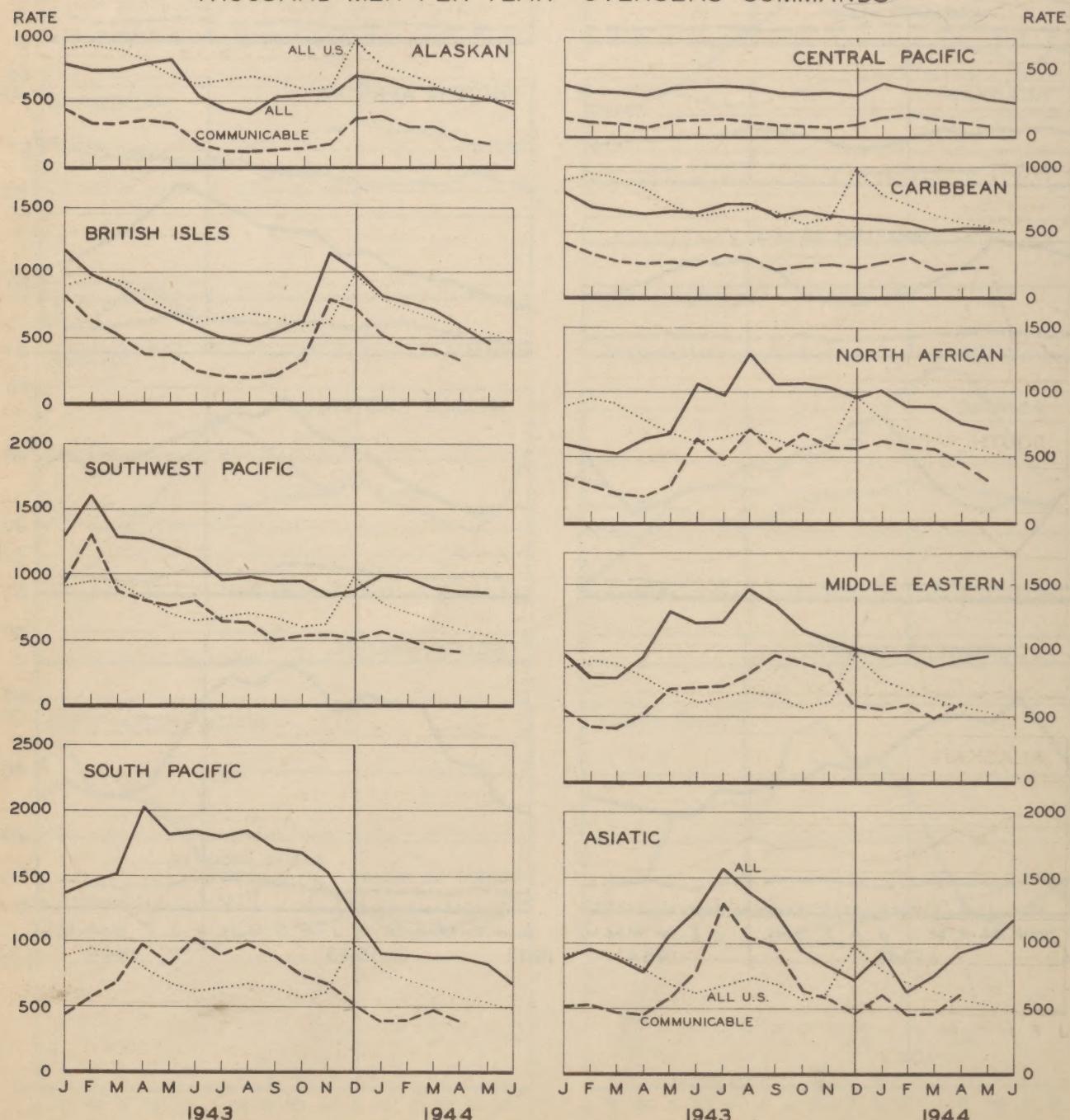
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## DISEASE AND INJURY

### DISEASE AND INJURY OVERSEAS

The charts below and on the following page compare the relative incidence of disease and injury among the more important overseas commands and the United States, the most recent points being based upon preliminary telegraphic reports. In all but the Middle Eastern and Asiatic theaters the admission rates for all diseases and for the communicable diseases declined during the first half of 1944. Although some part of the decrease in the South Pacific may be attributable to corrections in the reporting of admissions, there has been a significant improvement in health conditions in this theater. Notable declines have occurred in the incidence of malaria and diarrhea and dysentery, in response to the tightening of control measures and the lessening of combat activity. In the Caribbean Defense Command, the Central Pacific Theater, and the United States the most recent rates represent the most favorable experience of the entire war period. The preliminary June rate of 1,156 admissions per thousand men per year in the Asiatic Theater represents an increase of about 85 percent over the low point of 619 in February 1944. The 1944 seasonal changes are rather similar to those of 1943 in this theater.

ALL DISEASE AND COMMUNICABLE DISEASE, ADMISSIONS PER THOUSAND MEN PER YEAR - OVERSEAS COMMANDS



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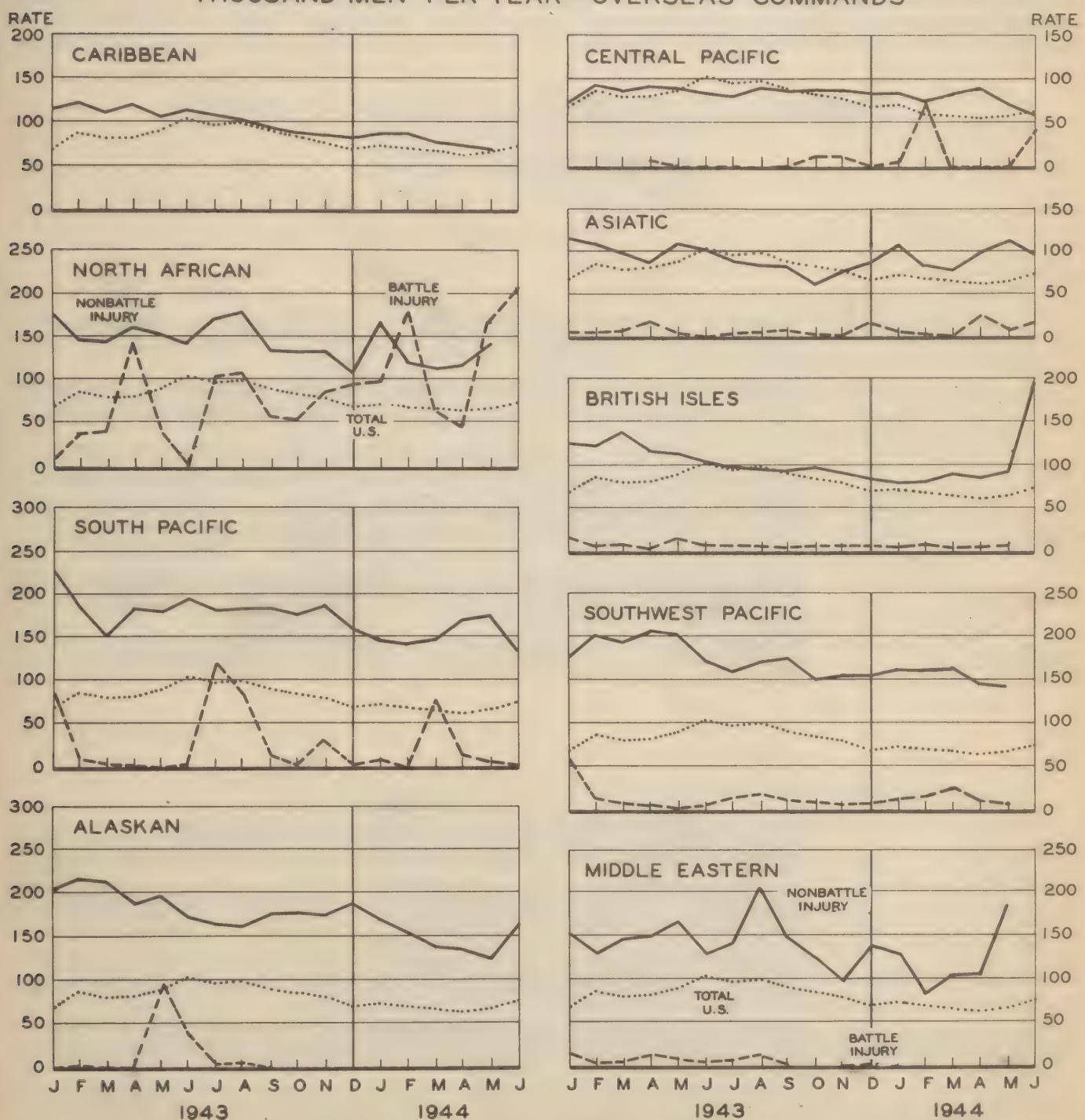
## DISEASE AND INJURY

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## DISEASE AND INJURY OVERSEAS (Continued)

During the first six months of 1944, admissions for nonbattle injury continued at a higher level for troops overseas than for those in the Continental U. S. In all theaters the most recent rates are preliminary, being based upon telegraphic reports. They indicate that the average incidence of nonbattle injury has gradually declined from the 1943 level. The fluctuating incidence of battle casualties in the various theaters records the periods of operational activity. Preliminary data indicate that the rates for the Central Pacific, European, and North African theaters were on the order of 45, 190, and 205 admissions per thousand men per year during June.

## NONBATTLE INJURY AND BATTLE INJURY, ADMISSIONS PER THOUSAND MEN PER YEAR - OVERSEAS COMMANDS



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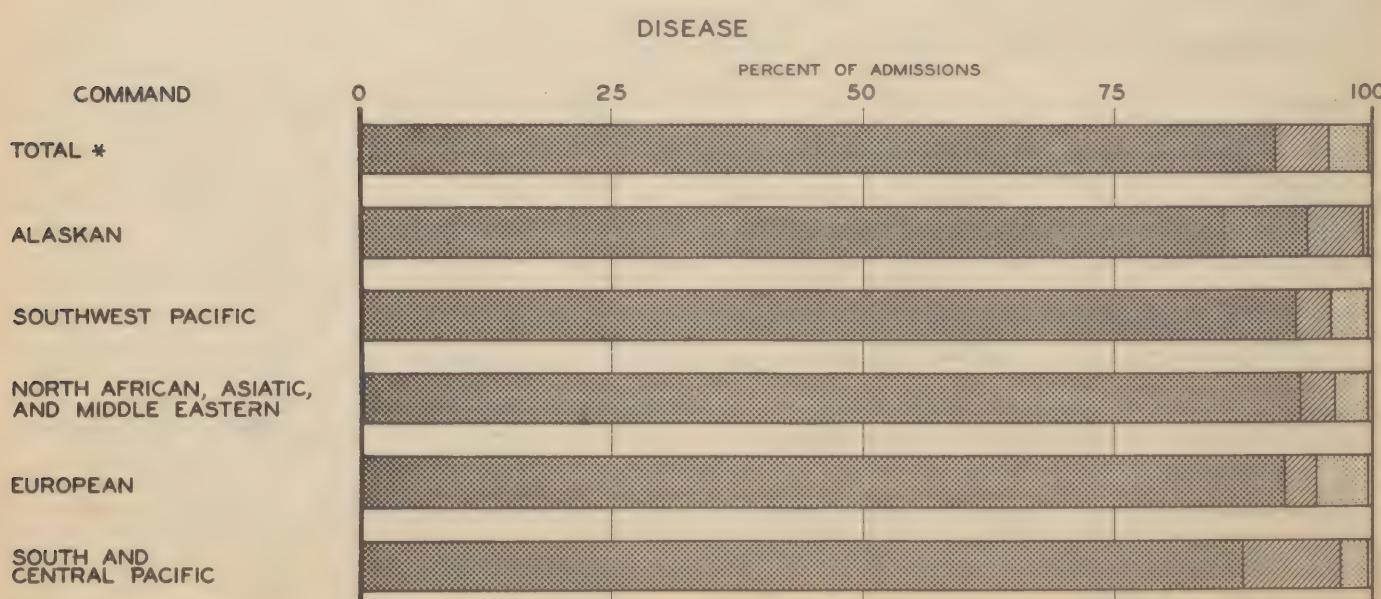
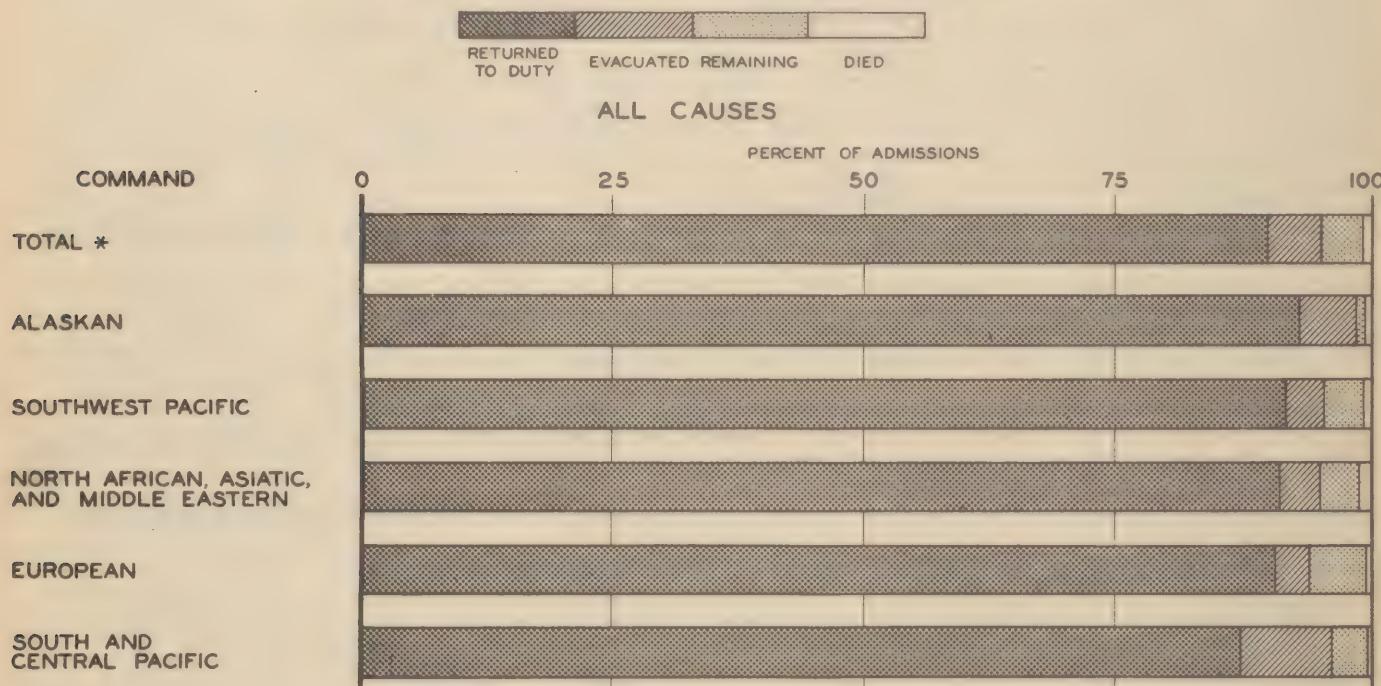
# DISEASE AND INJURY

## DISPOSITION OF ADMISSIONS

The Medical Department exists primarily to conserve the effective strength of the Army, and among the troops overseas it is essential that the maximum number of patients be returned to duty as quickly as possible if costly replacements are to be minimal. The disposition of admissions to hospital and quarters, therefore, is a matter of prime military importance. In March, HEALTH carried preliminary estimates for overseas theaters, showing the percentage of all 1942 and 1943 admissions who had returned to duty, had been evacuated to the U.S., remained in the theater at the end of the year, or had died of disease, nonbattle injury, or battle injury. Comparable estimates are now available for disease admissions, nonbattle injury admissions, and battle casualties, the period of admission having been extended to 30 April 1944.

Reports of admissions and dispositions of patients are made to The Surgeon General on the Statistical Health Report. It is known that the reports of the South Pacific Theater involve considerable duplication of admissions, so that the proportions for those who were evacuated, were remaining on sick list, or died must be regarded as understated. Moreover,

## DISPOSITION OF ADMISSIONS IN OVERSEAS THEATERS ADMISSIONS FROM JAN. 1942 - APR. 1944



\* For Commands Shown.

# DISEASE AND INJURY

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## DISPOSITION OF ADMISSIONS (Continued)

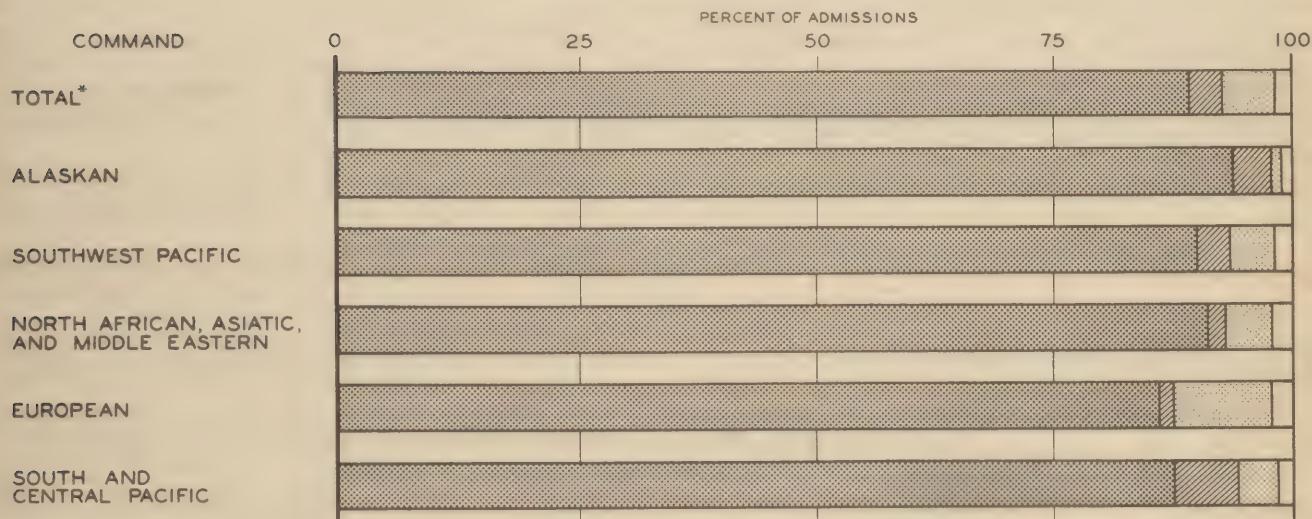
the admissions of certain commands may be returned to duty in others, having been transferred for hospitalization and convalescence, so that some theaters or other commands must be combined for purposes of estimation. This is particularly true of the South and Central Pacific sections of the Pacific Theater. The accompanying charts include no estimates for the Latin American section of the American Theater, and its experience is also omitted from the overseas totals shown there.

Estimates of the proportion of battle casualties returned to duty will vary depending upon the character of the recent admission experience, unless the previous experience is so extensive as to dominate the picture. In perhaps no command studied here has this degree of stability yet been reached. For battle casualty, nonbattle injury, and disease the percentages returned to duty are 64, 89, and 91 for all forces overseas. The percentages evacuated are 20, 4, and 5 in the same order. A higher incidence of battle casualties in the future may increase the proportion of battle casualties evacuated. The variations among the individual theaters are shown in the charts below and on the previous page.

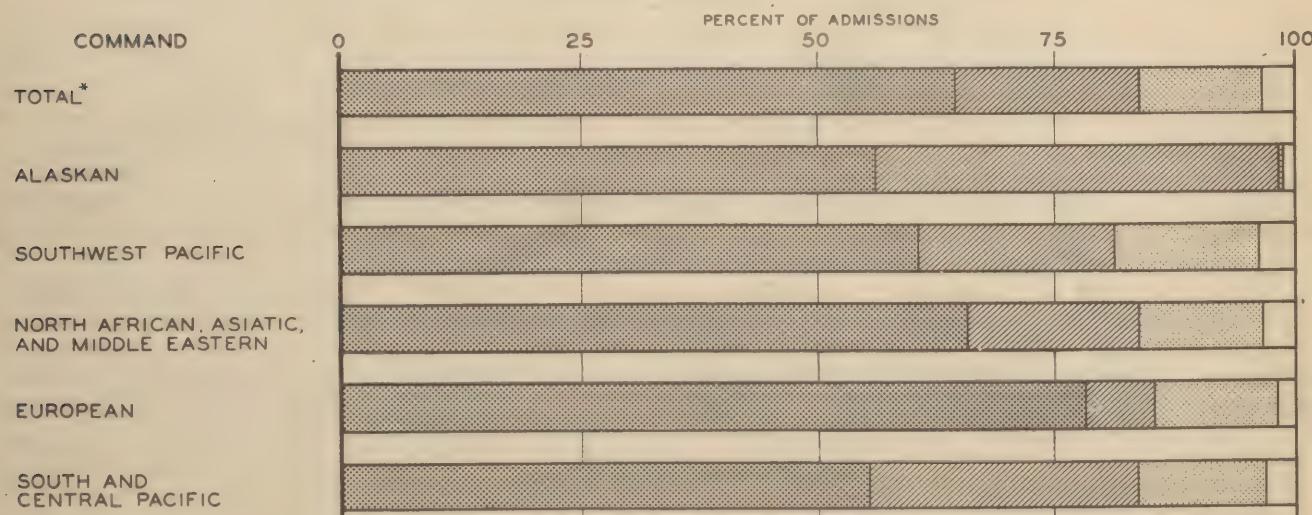
## DISPOSITION OF ADMISSIONS IN OVERSEAS THEATERS ADMISSIONS FROM JAN. 1942 - APR. 1944


  
 RETURNED TO DUTY    EVACUATED    REMAINING    DIED

### NONBATTLE INJURY



### BATTLE CASUALTY



\* For Commands Shown.

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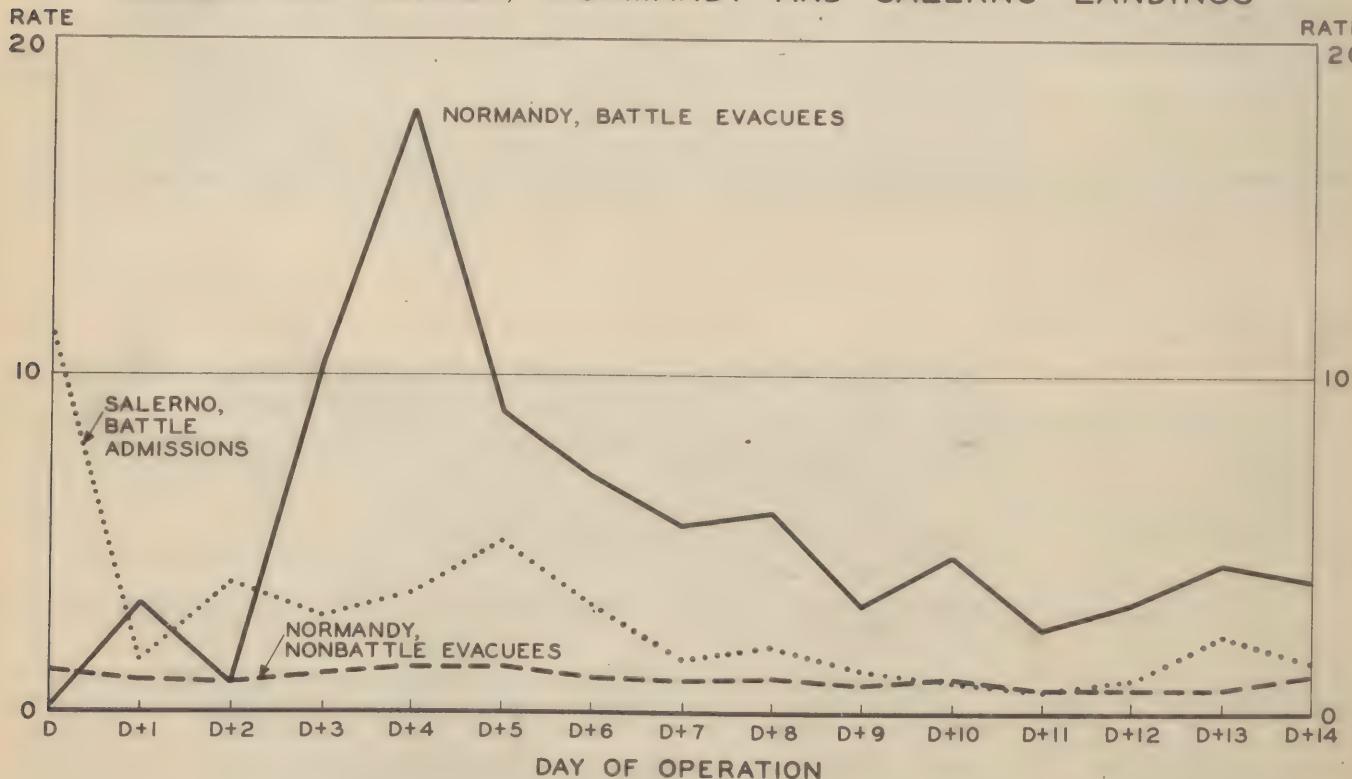
## DISEASE AND INJURY

### NOTE ON MEDICAL ASPECTS OF EUROPEAN LANDING OPERATION

Daily evacuation rates from the combat zone, ETO, are shown below for battle and nonbattle causes from D to D+14. The peak rate of evacuation occurred on D+4. For the entire period the evacuation rate was 6.1 per 1,000 men per day, of which 5.2 derived from battle and 0.9 from nonbattle causes. For a comparable period at Salerno the average admission rate was 2.4 per 1,000 men per day for battle casualties. The initial operation was remarkable for the evidently low incidence of disease and nonbattle injury of sufficient gravity to require evacuation. Not all nonbattle admissions were evacuated, but the evacuation rates for battle casualties are roughly comparable with admission rates for this period. Independent data extending to 7 July provide battle casualty admission rates of 9.5, 3.3, 2.9, and 0.6 per 1,000 men per day for each of the four weeks in chronological order.

Extensive use was made of the LST for purposes of evacuation, an experienced surgeon being placed on each LST together with two medical officers of the Navy and about 20 hospital corpsmen. This provision of expert surgical service on the LST's is credited with the saving of many lives; hundreds of casualties were carried from the beaches where they fell to the LST's for medical care. Returning LST's carried 150 to 300 patients in a single load and accomplished perhaps 90 percent of the total casualties evacuated in the early days of the operation. No air evacuation had been expected before D+7, but the Ninth Air Force established evacuation facilities on D+3. So successful was the air evacuation that it rapidly supplanted all other types of evacuation, and was taking place at the rate of about 1,000 men per day by 25 June. The provisions for receiving casualties in the United Kingdom were ample. At the points where evacuees were received, field hospitals of varying size, reinforced with surgical teams, were established to care for non-transportable cases. Other cases were sent to transit hospitals within a radius of 20 miles and these were evacuated daily by hospital train to general hospitals in northwest England. The casualties arriving in the United Kingdom give evidence of fine care. Ample quantities of whole blood, plasma, penicillin, and other medical supplies were available at all echelons. There was far less gas gangrene than had been expected because of the unprecedented speed with which surgery was made available, and possibly also because of the extensive use of penicillin.

### EVACUEES OR ADMISSIONS PER 1,000 MEN PER DAY FOR BATTLE AND NONBATTLE CAUSES, NORMANDY AND SALERNO LANDINGS



# DISEASE AND INJURY

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## PROBLEM AND CONTROL OF TRENCH FOOT

The past winter in Italy has revealed an unexpected inability on the part of front-line troops to protect themselves against the environmental hazards conducive to trench foot. The principles of prevention and treatment of this serious disorder are well understood medically. Conquest of trench foot awaits no new drug or method of prophylaxis; its control lies within the power of the Army at the present time, but the necessary measures must be individually employed, and hence carefully taught to each and every soldier, and lie within the province of command rather than medical authority.

Trench foot is the term applied to the condition resulting from prolonged exposure of the feet to cold and moisture. Dependency and immobility of the lower extremities, and their constriction by shoes or other clothing, are contributing factors. Trench foot differs from frostbite in that its development does not require freezing temperatures. Continued exposure in cold, wet trenches or foxholes, with restricted movement, and the wearing of wet socks and footgear, often for days on end without change, are the typical predisposing conditions. When military necessity requires such exposure it is essential that all preventive measures consistent with the military situation be enforced if serious and extensive injury is to be avoided.

## INCIDENCE AMONG U. S. TROOPS

Although considerable bodies of U. S. troops have been stationed in climatic zones where trench foot may occur, it seems probable that exposure has been minimal and that troops in the colder climates have been more rigorously trained in the hygiene of preventing cold injury of all kinds. The brief Attu campaign sounded a warning note which was either not heeded or misunderstood as a mere failure of equipment rather than of men and equipment. It is not known exactly how much trench foot occurred there but at the end of May, when 12 percent of the landing force was noneffective, about 4 percent was noneffective because of "exposure", a large portion of which is believed to have been trench foot. The brevity of the campaign probably prevented the development of many cases to the trench foot stage, and most of the cases diagnosed as trench foot were apparently relatively mild. Observations have been made which suggest that certain of the troops, accustomed to wet, cold weather, understood the need for proper care of their feet and did not develop the symptoms. It is also believed that the high-top, laced, leather boot used in that operation was more conducive to trench foot than was the rubber-bottom shoe pac.

Although medical officers were aware of the problem of trench foot, it received no real recognition in the training of troops for service overseas. In consequence, trench foot caused about 5,000 admissions in North Africa during the four months ending with March 1944. By the very nature of the injury these men were front-line troops whose replacement was a military necessity. Moreover, so poorly understood was the condition that many men first sought medical help only after their symptoms were rather advanced, and the average number of days lost per case is probably 7 to 8 weeks. The accompanying chart gives the admission rate for the Fifth Army over the period in question.

When trench foot first appeared in Italy early in November, after a period of cold with continuous rain, many troops were still wearing cotton socks. However, the light woolen sock was soon issued and unit commanders were instructed to see that men carried extra socks and removed shoes and changed socks whenever possible. Heavy woolen socks were later issued and some troops were given arctic clothing. Despite these precautions, trench foot continued to increase in the Fifth Army and during January and February there were 2,800 admissions for trench foot in comparison with 12,900 admissions for battle wounds, a 1 to 4.6 ratio. The significance of this high incidence is strengthened by the fact that the average case of trench foot requires so long a time for recovery that some cases are unable to return to duty and a few may suffer the loss of limbs.

Several studies have been made in the theater in an effort to determine why trench foot proved so serious and how it might be prevented. These observations have established that present equipment alone will not provide a solution to the problem, and that assiduous care of his feet by the individual soldier is essential if adequate protection is to be obtained. If men do not understand the necessity for keeping the feet as dry and clean as possible, change of socks, avoidance of militarily unnecessary exposure, loose-fitting boots of water-proof or water-resistant material, use of innersoles and socks, exercise of toes and ankles and gentle massage to promote circulation, and the like, then severe exposure, as in Italy, will inevitably exact a heavy and unnecessary toll. A sample of 142 men with trench foot were interviewed as they passed through a clearing station in late January and early February. With rare exceptions the men were not wearing heavy woolen socks. They had

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## DISEASE AND INJURY

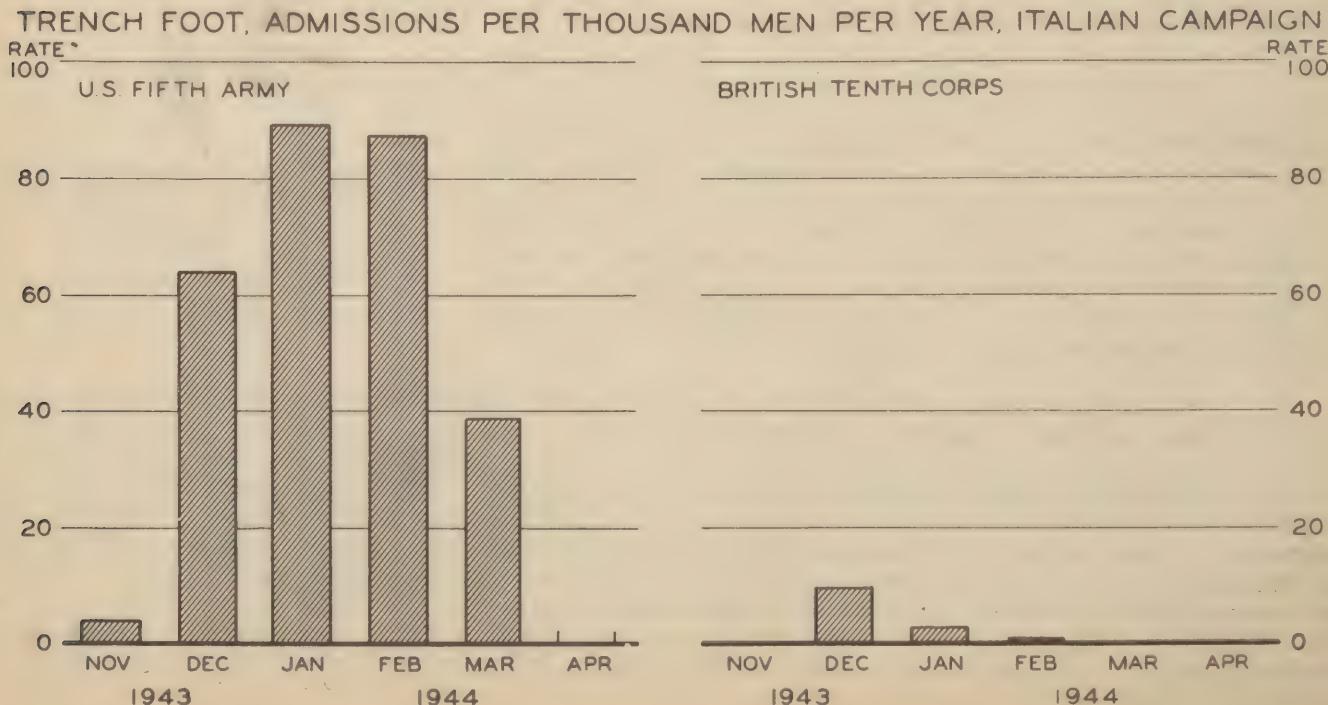
### PROBLEM AND CONTROL OF TRENCH FOOT (Continued)

not been instructed in the proper care of their feet. One man had changed his socks but 3 times in 6 weeks. None of the men understood that foot trouble might result from resting in the cold with wet shoes, socks, and feet. None understood how to use overshoes to best advantage. Similarly, a survey of 129 3rd Division cases, mostly from the Anzio beachhead, showed the importance of length of service in determining the risk of developing trench foot. Although only 4 percent of the infantrymen in the 3rd Division had been overseas only one month, over 30 percent of the cases of trench foot were in this group; in other words the incidence among this group was more than 8 times the average incidence for the division according to this sample. It was found extremely difficult to impress new replacements with the necessity of taking care of their feet during periods of military activity. The officer preparing the basic report included the following remark: "I have never seen a new replacement in this theater who had received instruction in the prevention of trench foot prior to joining the division." An enlisted man wrote to his ward surgeon as follows: "Not a single person I talked to, out of many in the hospital with trench foot, had ever heard of the ailment until he was told that he had it. Since it is putting so many men out of action, I think it would be well worth an effort on the Army's part to inform the soldier on the subject before and not after he has it. Printed matter on the subject is all right but too often printed matter is discarded, before reading, as nonsense. Printed matter on the subject should at least be supplemented by a talk given to soldiers by a Medical Officer .... Officers and Non-com's should be held responsible for seeing that each soldier takes care of his own feet...." However, most of the men with a year or more of service overseas had seen action on the southern Italian front, and knew about trench foot and its prevention. A larger sample of 320 cases including those from the 3rd Division was questioned about the circumstances surrounding their injury, with the following results, in part:

1. Fifty-nine percent had never received instruction in the prevention of trench foot.
2. Eighty-six percent had lain in a wet slit trench or foxhole immediately prior to the onset of trench foot.
3. Eighty-seven percent had but 1 pair of shoes available to them while in combat.
4. Sixty-four percent had found it impossible to keep their shoes dry.
5. Twenty-six percent did not remove their shoes even once during the week prior to admission.

### POSSIBILITY OF CONTROL

There is ample evidence of the possibility of adequate control. In the last war, under circumstances far more inimical, the British Expeditionary Force in Flanders suffered heavily in 1914, but progressively less so thereafter because of rigid control measures enforced by command. The average annual rate for the BEF for the years 1916 to 1918 when the control program was in full effect, was about 9 admissions per 1,000 men per year. The 5th



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# DISEASE AND INJURY

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## PROBLEM AND CONTROL OF TRENCH FOOT (Continued)

Army rate for a full year will be perhaps 20 to 25, or more than twice the World War I British rate. A second factor pointing to the possibility of control is the wide variation observed with respect to the incidence among divisions in Italy. When allowances are made for exposure and combat activity it appears that certain divisions suffered much less than others, suggesting that their efforts at control were more fruitful. By far the most powerful argument, however, is contained in the record of the British 10th Corps, which has experienced conditions in Italy closely paralleling those of the Fifth Army. The British rates are plotted in the accompanying chart for the period November through April. In November, March, and April there were no reported cases, and the December rate of 9.4 per 1,000 men per year was the highest of the winter. The 5th Army rates for January and February were almost 10 times the peak British rate. The British equipment included heavy woolen socks, loosely fitting shoes of heavy leather, and short leggings, but superior equipment alone would not be expected to make the difference. It seems fair to infer that the foot discipline of the British troops was excellent in contrast with that of U. S. troops. Certainly during the last war the British rapidly learned and realized upon effective methods of prevention.

## PROGRAM FOR CONTROL

Like venereal disease and malaria, trench foot can be prevented only by the intelligent behavior of the individual soldier under conditions of exposure. He must, therefore, understand the danger, realize that trench foot is too serious an injury to court as a ticket to the hospital, and be aided in the proper methods of foot hygiene. He needs the best possible equipment from the standpoint of keeping warm and dry, and every effort consistent with military necessity should be made to minimize his exposure and to remove him at frequent intervals to a point where control measures may be employed. The basic principles of prophylaxis are (1) conservation of body heat and (2) avoidance of unnecessarily prolonged exposure of the feet to coldness, moisture, and other factors tending to reduce the circulation. The individual points in a control program are:

### 1. Provision of Suitable Equipment.

- a. Loose-fitting water-proof or water resistant boots with thick, replaceable, felt innersoles. The shoe-pac may be best for this purpose except on rough, mountainous terrain.
- b. A plentiful supply of heavy woolen socks, and also felt innersoles if these are used.

### 2. Avoidance of Unnecessary Risk.

- a. Standing or resting in water or mud-soaked areas should be avoided as much as possible.
- b. Cramped positions, prolonged immobility, and dependency of the extremities should be avoided. These can be counteracted by stationary exercise of the feet and legs.
- c. In cold wet weather troops should be rotated and relieved from front line duty as often as the tactical situation permits.

### 3. Enforcement of Adequate Individual Hygiene.

- a. Wet socks or innersoles should be changed to dry ones as often as possible. Troops should carry a dry, extra pair at all times.
- b. Shoes should be removed at least once daily, and the feet cleaned, dried, and dusted with foot powder.
- c. The upper part of the body should be kept as warm and dry as possible.
- d. Non-commissioned officers must be prepared to supervise their men in the care of their feet. Foot inspections every few days by unit commanders will be valuable in enforcing proper foot hygiene and also in detecting any early symptoms of the injury when men are exposed to trench foot.

A War Department circular has been prepared setting forth the essential principles of control and emphasizing the command responsibility for their application. However, the success of the control program will rest upon the thoroughness with which the individual soldier is trained in the prevention of trench foot and upon the quality of its enforcement by command. The number of men already overseas is so great that much of the training must be done there, but the proper training of troops in the U. S. is no less essential. A winter campaign in northwestern Europe could create a trench foot problem of major importance if the lesson of Italy were not heeded.

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## DISEASE AND INJURY

### BATTLE CASUALTIES BY ARM OR SERVICE

There are wide variations among the arms and services in the average casualty rates experienced since the beginning of the war, variations which are not constant within theaters and which in some instances are accentuated when officers and enlisted men are separately considered. There are also characteristic differences in the type of casualty experienced by certain of the arms. The material which follows is based on all casualties (including the Philippine) processed by The Adjutant General prior to 1 June 1944, which may, for practical purposes, be taken as all casualties occurring through April 1944. Strengths through that date have accordingly been employed in computing relative incidence. The variations among theaters with respect to lags in reporting introduce only negligible errors.

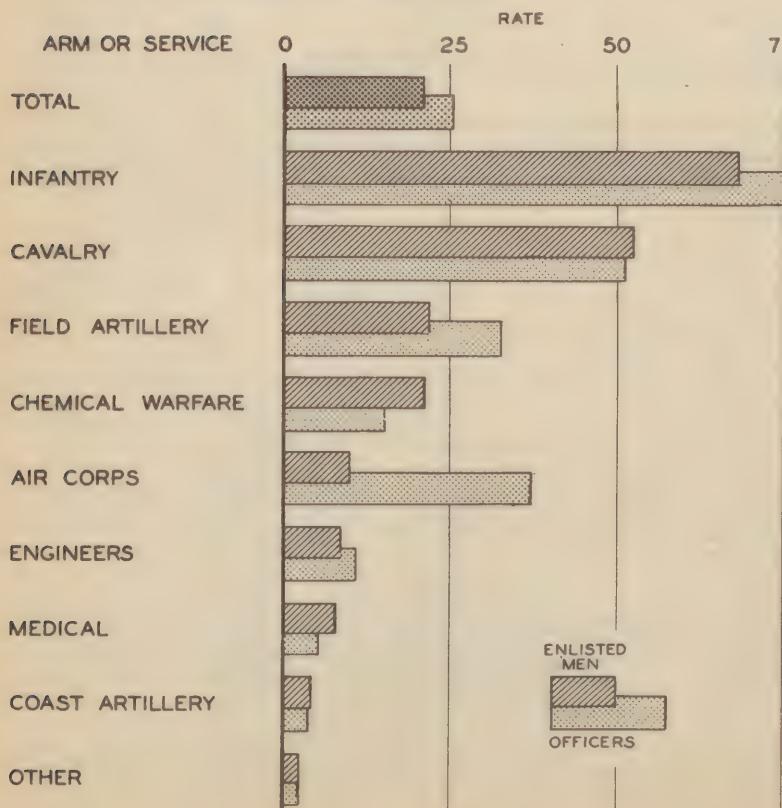
Eight arms and services were selected as having especially high casualty rates for all causes, and their average rates are shown below in both tabular and graphic form. The total casualty rate of 52 per 1,000 strength per year for all arms and services is compounded of 8 for killed in action, 22 for wounded in action, 10 for captured and interned, and 12 for missing in action. If the Philippine campaign is excluded these individual rates become 8, 21, 7, and 7, the total being 43 per 1,000 strength per year. The body of the table reveals tremendous variation in the rates for individual arms and services. The high rate for Cavalry is noteworthy even if the Philippine experience is excluded, for a high proportion of its

BATTLE CASUALTIES PER 1,000 MEN PER YEAR OVERSEAS, BY ARM OR SERVICE  
December 1941 through April 1944

Type of Casualty	Arm or Service									
	Total	Air Corps	Coast Artillery	Cavalry	Corps Engineers	Chemical Warfare	Field Artillery	Infantry	Medical Dept.	Other
Total	52.4	92.4	22.1	124.8	18.8	46.9	51.5	113.9	18.2	10.0
Killed	8.3	17.4	1.6	14.0	3.6	7.7	5.9	18.2	2.3	1.2
Wounded	21.7	13.8	4.9	52.6	9.3	21.1	22.9	68.9	8.0	2.9
Captured	10.4	26.7	12.4	7.9	2.6	6.3	7.1	13.1	4.7	2.6
Missing	12.0	34.6	3.3	50.4	3.4	11.9	15.6	13.7	3.2	3.3

BATTLE CASUALTIES PER 1,000 MEN PER YEAR BY ARM OR SERVICE  
DECEMBER 1941 THROUGH APRIL 1944

### WOUNDED IN ACTION



### KILLED IN ACTION



## DISEASE AND INJURY

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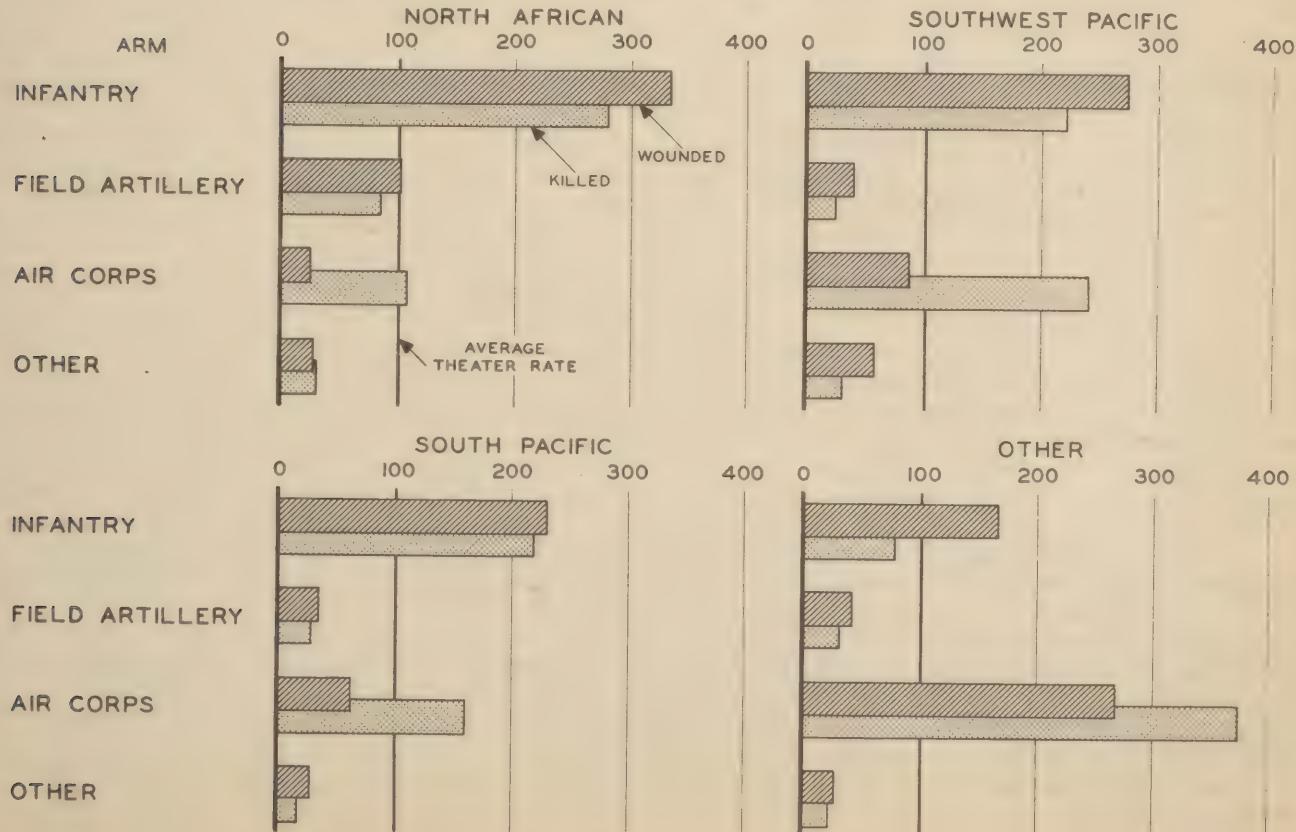
## BATTLE CASUALTIES BY ARM OR SERVICE (Continued)

small strength has been actively engaged as dismounted infantry. With this exception the Infantry has the highest rates for killed in action and for wounded in action, but the Air Corps has the highest rates for both captured and missing. Except for the Air Corps, the order of the arms and services is maintained when officers and enlisted men are considered separately. So many Air Corps officers are fliers that their average casualty rate is twice as high as that for Infantry officers. The components of the rate of 278 for Air Corps officers are 55 for killed in action, 37 for wounded in action, 75 for captured or interned, and 110 for missing in action.

Comparison of the rates for the various arms and services in individual theaters is rendered difficult by the great differences in their operational history. However, this has been overcome in the charts below by expressing the rate for each arm or service as a percentage of the average rate for all arms and services in the particular theater. Only the rates for Infantry, Air Corps, and Field Artillery are shown for the most active theaters. Since there has been considerable ground activity in these theaters, the Infantry rates are uniformly high for wounded, but the Air Corps rate for killed is highest in the Southwest Pacific where extensive use has been made of the air arm. The accompanying table gives the individual rates of incidence by type of casualty, the Philippine casualties being included under "other". The Air Corps experience in ETO dominates the rates for "other" theaters.

BATTLE CASUALTIES PER 1,000 MEN PER YEAR OVERSEAS, BY THEATER AND BY ARM  
December 1941 through April 1944

Arm	Killed				Wounded				Captured				Missing			
	SWPA	SPA	NATO	Other	SWPA	SPA	NATO	Other	SWPA	SPA	NATO	Other	SWPA	SPA	NATO	Other
Total	6.4	7.7	19.4	4.6	13.6	27.0	67.9	5.0	2.6	0.0	13.1	12.5	4.5	2.0	10.5	15.6
Air Corps	15.5	12.4	20.9	17.2	11.9	16.5	16.0	13.3	1.8	0.1	11.5	37.1	21.2	15.5	22.0	41.7
Field Art.	1.6	2.1	16.5	1.4	5.3	9.0	68.9	2.0	17.6	0.0	13.1	2.1	4.3	0.1	1.7	31.8
Infantry	14.2	16.9	54.6	3.5	38.8	62.0	225.8	8.3	1.4	0.0	42.2	6.0	1.5	0.7	25.0	14.4
Other	2.0	1.2	5.9	1.0	7.7	7.3	18.6	1.3	1.4	0.0	2.3	7.3	0.5	0.8	3.7	5.7

COMPARATIVE INCIDENCE OF BATTLE CASUALTIES, ARMS AND SERVICES,  
ACTIVE THEATERS, DECEMBER 1941 THROUGH APRIL 1944  
PERCENT OF AVERAGE THEATER RATE

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## DISEASE AND INJURY

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### SALVAGING NEUROPSYCHIATRIC PATIENTS

During the six months ending March 1944, the Army discharged about 75,000 men for neuropsychiatric disability (Section II only). However, during this period the rate of discharge has fallen from 35 to about 13 discharges per 1,000 men per year, chiefly because of the decision by the War Department to make use of such men within the organization of the Army. The policy of utilizing men according to their capacity, as first promulgated in WD Circular No. 293, dated 11 November 1943, provided the basis for a real attempt to salvage neuropsychiatric patients who formerly would have been discharged with little effort by the Army to adapt them to its work. It is not yet known, however, how successfully the Army has used the men retained under this policy.

The problem of salvaging neuropsychiatric cases is posed in full force under combat conditions, when appreciable numbers of battle reaction cases must be handled. However, as has been demonstrated so well in North Africa, the return to duty of a large majority can now be assured by administering early and adequate treatment forward before symptoms become fixed. Others may be returned to duty after evacuation to the rear, but the bulk of the saving is made at the level of the evacuation hospital or even the clearing station. Although some additional improvements may be expected in the proportion of exhaustion or battle reaction cases returned to duty, the chief problem concerns the men whose admissions were precipitated by other circumstances. Every theater has its undercurrent of admissions on the part of maladjusted individuals whose problems have been brought to the fore or accentuated by misassignment, poor direction and leadership, boredom, and stress of various kinds. In the Southwest Pacific three station hospitals have been established in advance base areas to care for mild neuropsychiatric cases exclusively. These hospitals provide a well-organized program of work and recreation as well as group and individual psychotherapy. More than three-fourths of the mild neuropsychiatric admissions to the special psychiatric hospitals have been returned to duty and comparatively few have required re-hospitalization. Neuropsychiatric hospitals have existed in the European Theater for some time, but the plans for the invasion provided further elaboration of the specialized set-up for the treatment and evacuation of neuropsychiatric patients, even including a clearing station to serve as a mobile N-P unit to receive the patients of evacuation hospitals forced to move forward. In other theaters similar efforts are being made to develop the special programs required to speed convalescence and to salvage the maximum number of neuropsychiatric admissions.

In December 1943 Army regulations were modified to provide for the treatment of those patients whose return to duty might thus be assured, and this policy was later implemented by the publication of a technical bulletin on methods of treatment. However, the present administrative duties and the shortage of psychiatric personnel in the U. S. are such that the entirely successful treatment of psychoneurotic patients cannot be expected at the present time. It will be necessary to concentrate patients and psychiatrists in centers large enough to make intensive use of the special talents of the psychiatrist, and to enlarge his influence through the work of such auxiliary personnel as clinical psychologists, psychiatric social workers, educational and physical reconditioning instructors, and occupational therapists. Moreover, both theoretical and practical considerations point to the desirability of removing from the hospital environment all psychiatric patients not actually requiring the closed-ward type of care. Hospitalization gives such patients an exaggerated notion of the severity of their illness, invites them to vest their neuroses with physical complaints, and frequently exercises a deleterious influence upon the convalescence of other patients. Some patients can continue on a duty status if out-patient treatment can be provided, and such facilities are being provided on an increasing scale. Out-patient clinics are maintained by psychiatrists assigned to divisions and replacement training centers as well as in an ever-expanding group of station hospitals. For the great bulk of the psychoneurotics, however, the fact of admission to hospital merely illustrates their inability to meet the requirements of ordinary duty and such individuals must be treated on a patient status.

The feasibility of salvaging neuropsychiatric patients has recently been well demonstrated by the success of the three developmental training units set up experimentally to retrain psychoneurotic patients amenable to such retraining. A group of 1,253 psychoneurotics were selected from hospitals and assigned to special duty at three ASF Training Centers. Men who were disoriented, discouraged, suspicious, and hostile upon arrival at the retraining centers gained confidence in the ability and willingness of the Army to make intelligent use of them. The Army skills which they learned or strengthened there facilitated their assignment and at the conclusion of the experiment 70 percent were deemed fit for limited duty assignments in Z.I. non-combat units. Their subsequent history will be followed with interest.

## DISEASE AND INJURY

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### SALVAGING NEUROPSYCHIATRIC PATIENTS (Continued)

The magnitude of the current and prospective problem in the U. S. is illustrated by the census of about 17,000 neuropsychiatric patients at the end of May, and by the prospective load of perhaps 40,000 neuropsychiatric evacuees to the U. S. during the remainder of the year. The peak load of patients at any one time is expected to be about 25,000, of whom roughly 17,000 would be open-ward cases and 8,000 closed-ward cases according to the present hospital distribution. It is planned to care for the closed-ward patients (psychotics) and the neurological cases in the psychiatric and neurological centers established within the general hospitals, and to transfer most of the open-ward patients to the neuropsychiatric sections of convalescent facilities which have just been designated in each service command. Patients from overseas are already moving into centers in the First, Second, and Eighth Service Commands. Present plans will provide for a capacity of perhaps 6,000 to 10,000 patients which may be increased as required. All psychoneurotics from overseas, or from Z. I. hospitals having too few such cases to justify the institution of a suitable program, will be transferred to the neuropsychiatric sections.

A program of reconditioning has been designed to return to duty the highest possible proportion of patients. The use of skilled personnel other than neuropsychiatrists will permit group activities of proven therapeutic value in addition to a limited amount of individual therapy. The plan calls for 5 psychiatrists, 2 psychologists, and 10 psychiatric social workers for every 500 patients. The use of barracks rather than general hospital beds for overseas patients will free a certain number of general hospital beds for patients unsuited for treatment on a convalescent basis. A well planned program will prevent apathy, morbid introspection, and preoccupation with physical manifestations of emotional disturbances, and focus attention upon constructive recreational and educational activities. Individuals not capable of returning to duty will be discharged. Other individuals will be recommended for full duty if possible, and otherwise for limited duty, after appropriate physical as well as psychiatric reconditioning. Indicated special assignments will be recommended in accordance with existing directives.

The expectancy of recovery will pervade the atmosphere of the camps. Although they will be carried as patients, the men will be treated as trainees and placed under suitable military discipline. Most men will have a four-week program, but some individuals may receive more extended retraining if indicated for return to duty. It is also expected that the ASF Training Centers will operate advanced retraining units to which some men may be sent for further training upon completion of the reconditioning program. Otherwise it would be necessary to maintain a separate advanced program for such individuals within the neuropsychiatric sections. The activities of the reconditioning centers will be carefully planned and will be compulsory with elective features. They will include physical reconditioning, psychotherapy, occupational therapy, education, and recreation. The physical reconditioning will be suited to the capacity of the trainee and correlated with his recreation. Competitive sports will be emphasized. Psychotherapy will be chiefly of the group variety, but some individual work will also be done. The occupational therapy will be flexible and geared to the interests of the men and to the educational program. Education is visualized largely as a means of improving motivation and orientation toward the war, using all manner of visual aids, lectures, group discussion, and the like.

Salvaging neuropsychiatric admissions for duty must be distinguished from the process of effecting a complete cure. The definitive treatment of neurotic illness is a difficult, time-consuming process at best. However, men can be better adjusted to their difficulties and to what is expected of them, and without definitive psychotherapy. Similarly, it is outside the recognized province of the Army to rehabilitate men emotionally in preparation for their discharge to civilian life; the resources of the Army must be directed toward the conservation of its effective manpower. Nevertheless, it is unfortunately true that no organized provision yet exists for the care of men discharged on neuropsychiatric grounds unless they are psychotic and require hospitalization, in which case the Veterans Administration will provide the necessary facilities. Furthermore, the present system of pensions in some cases plays into the hands of the illness and, like discriminatory treatment by prospective employers, deters efforts to seek treatment after discharge from the Army.

The possibility of retraining many neuropsychiatric cases for useful Army duty now seems assured. However, their effective utilization is by no means certain. Despite the rather specific provisions of WD Circular No. 293 (1943), little has been done to implement the process of assignment. The Medical Department can divest neuropsychiatric admission of its tendency to provide a vehicle of exit from the Army and can bring patients to a point where classification experts judge them prepared to return to specified duties, but it cannot superintend the process of assignment. The whole program of salvaging these men assumes that the Army not only can but will utilize men of limited capacity.

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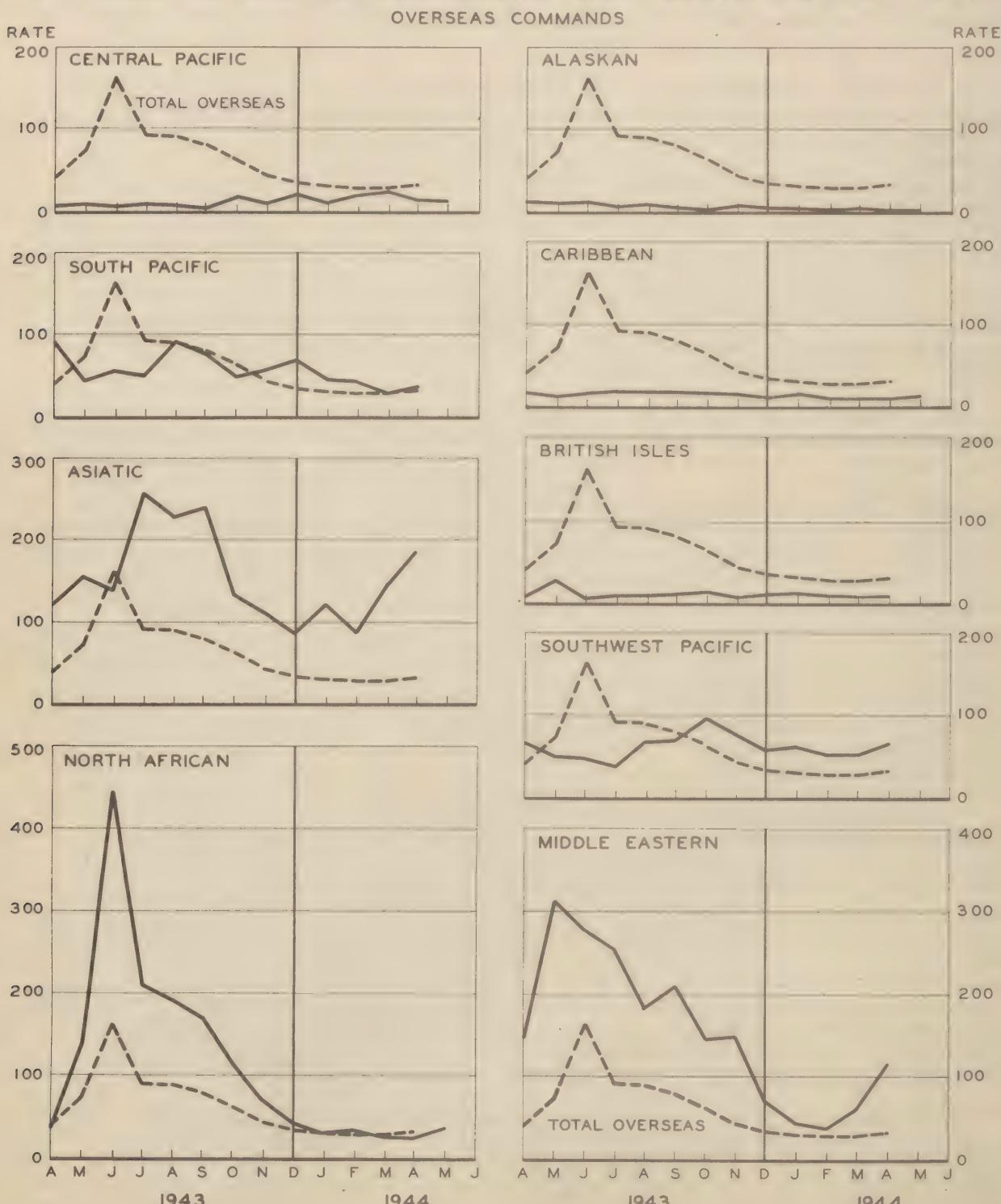
# DISEASE AND INJURY

**RESTRICTED**

## DIARRHEA AND DYSENTERY OVERSEAS

During March, April, and May, there was a general increase in the prevalence of diarrhea and dysentery overseas, but the May reports are not available for most theaters as **HEALTH** goes to press. The outstanding changes are those which have occurred in the Asiatic and Middle Eastern theaters, but there was also a significant increase in the Southwest Pacific Theater. The average level of the incidence in the Central Pacific is now considerably higher than it was in 1943, but the 1944 South Pacific experience is more favorable than was that for 1943. Last year North Africa experienced a sharp rise in May followed by an epidemic peak in June. This year a low level was maintained through May, but telegraphic information for June suggests that a real increase is now under way.

### DIARRHEA AND DYSENTERY, ADMISSIONS PER THOUSAND MEN PER YEAR



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## DISEASE AND INJURY

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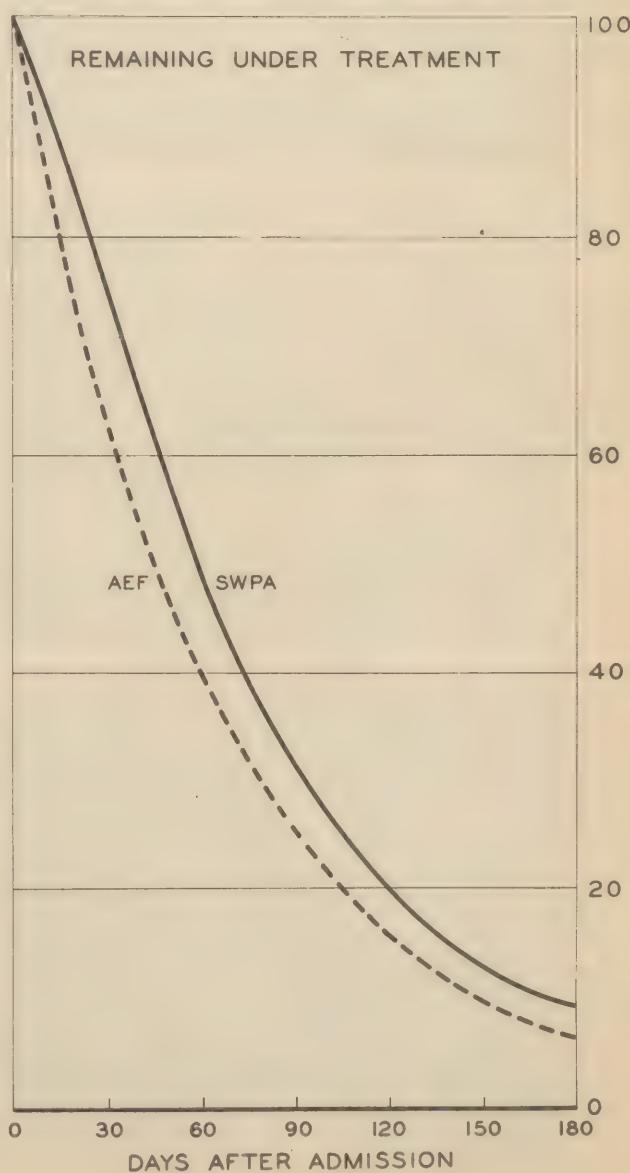
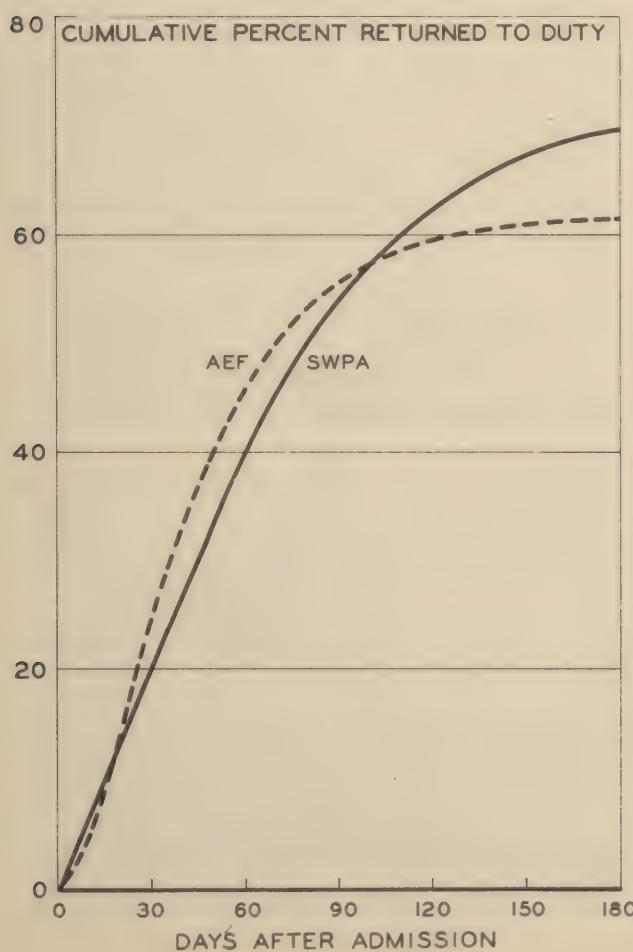
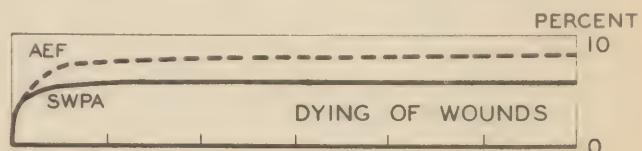
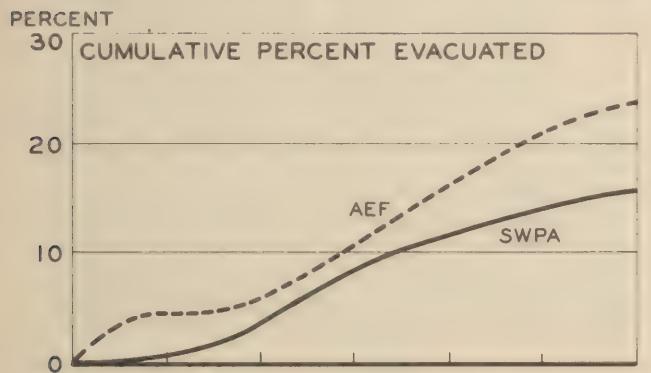
### BATTLE CASUALTIES IN THE SOUTHWEST PACIFIC

The Southwest Pacific Theater has recently completed an excellent study of all the battle casualties admitted to sick report prior to 1 September 1943, and showing the proportions of patients remaining under treatment, returned to duty, evacuated, and dying of wounds at stated intervals after admission. The cardinal features of the study, covering 2,600 cases, are shown below graphically in comparison with the experience of World War I.

The percentage of admissions remaining under treatment is appreciably higher for the Southwest Pacific during the first few months after admission, largely because of the lesser rate of evacuation from this theater. The proportion of patients returned to duty follows the World War I experience rather closely for the first 90 days, but the tendency to retain long-term cases enabled the Southwest Pacific to return 70 percent to duty by the end of 180 days in comparison with 62 percent in World War I. In this connection it should be recalled that the sudden end of World War I caused the evacuation of many patients who would

### HOSPITALIZATION AND DISPOSITION OF BATTLE CASUALTIES

A.E.F., W.W.I AND SOUTHWEST PACIFIC ADMISSIONS PRIOR TO 1 SEPTEMBER 1943



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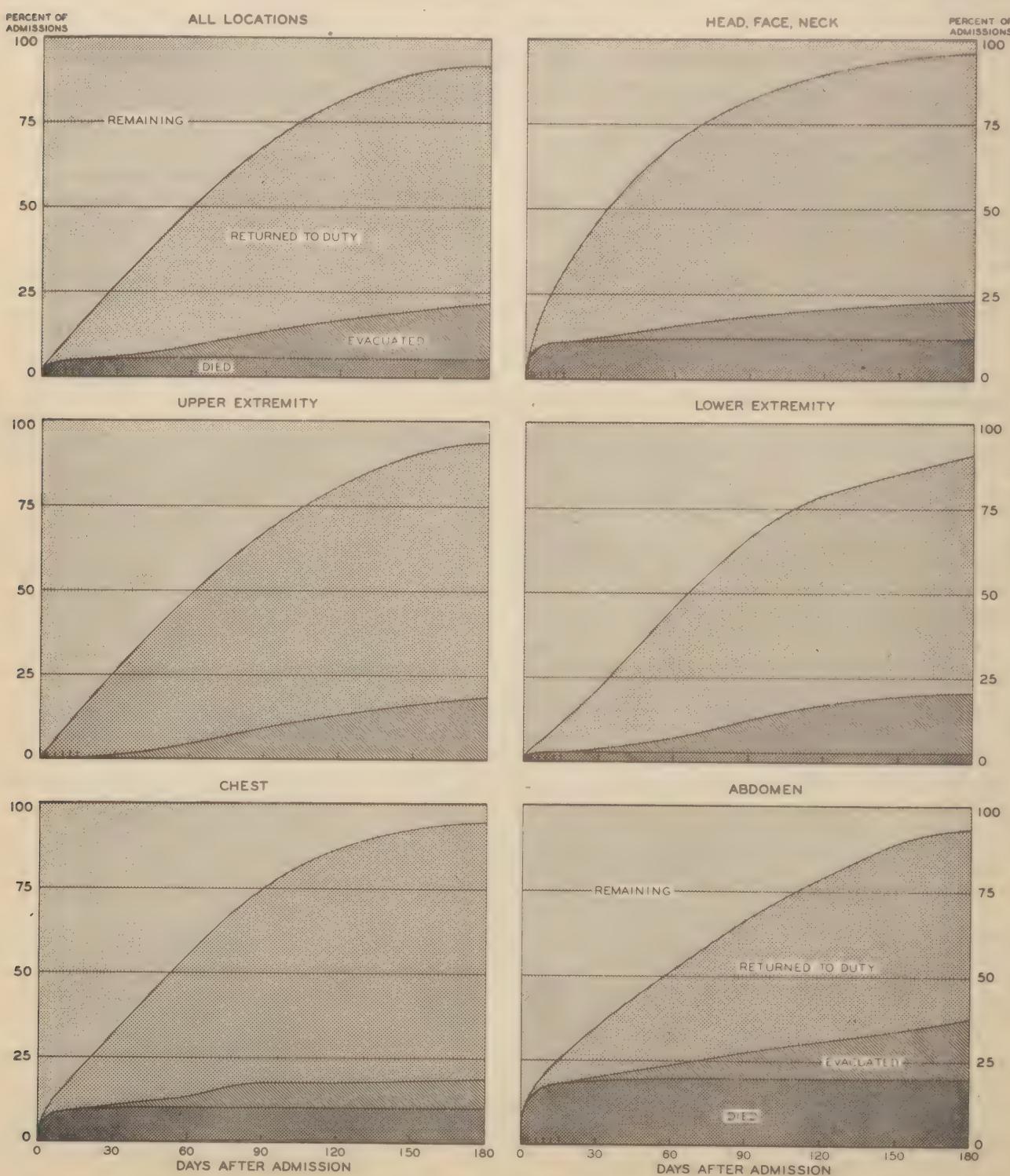
## DISEASE AND INJURY

### BATTLE CASUALTIES IN THE SOUTHWEST PACIFIC (Continued)

otherwise have returned to duty overseas. The similarity for the first 90 days suggests that, in this theater at least, there has been no real improvement over the World War I rate at which wounded were returned to duty.

The smallest panel, showing the curve of deaths in percentage form, indicates that the chance of survival for all wounded men admitted to sick report in the Southwest Pacific is much greater than the corresponding rate in World War I, especially after the first few days following admission. The similarity of contour illustrates the point that the factors

HOSPITALIZATION AND DISPOSITION OF BATTLE CASUALTIES BY REGIONAL LOCATION  
SOUTHWEST PACIFIC



## DISEASE AND INJURY

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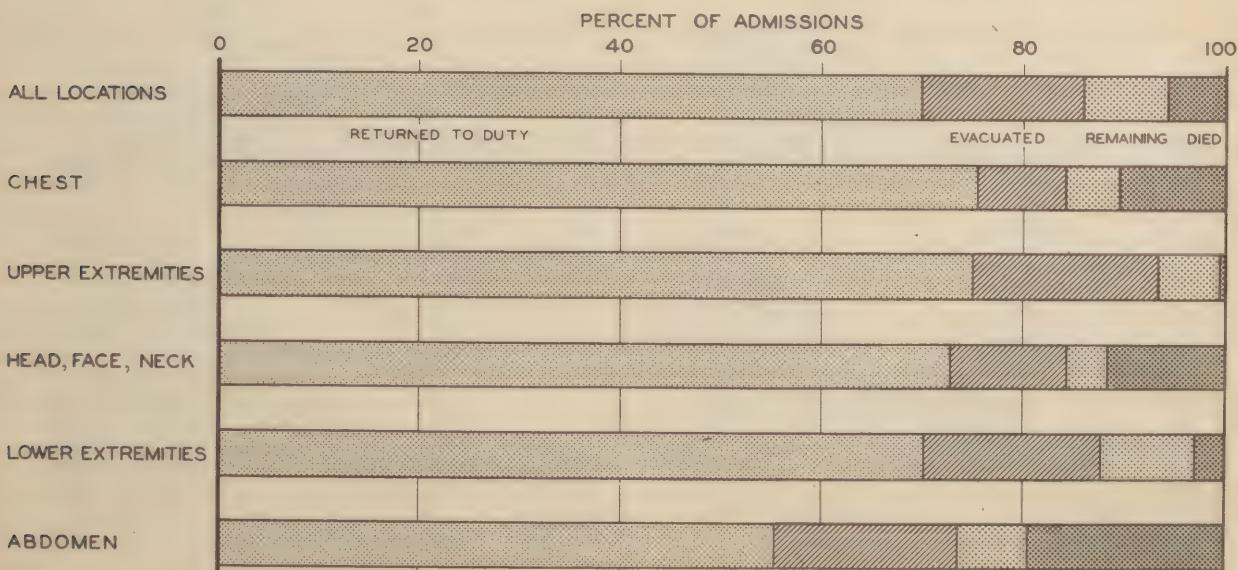
## BATTLE CASUALTIES IN THE SOUTHWEST PACIFIC (Continued)

governing life and death among battle casualties, that is, the traumatic destruction of tissue and the consequent reaction of the organism, are essentially unchanged. World War II fatality estimates from other sources (see HEALTH for April 1944) are generally lower than the 5.6 percent reported by the Southwest Pacific. However, the latter was developed with such care as to cast doubt on other and lower estimates covering the experience of this theater. It may still be true that the fatality percentage is typically higher in the Southwest Pacific than elsewhere overseas. Fatality rates by location of wound appeared in the April issue of HEALTH for hospital admissions in North Africa.

The panel on evacuation provides data which run counter to accepted notions of the operation of a 120-day evacuation policy. It would be expected that patients requiring more than 120 days of hospitalization would be evacuated as quickly as possible, the bulk of them between 30 and 60 days, and all by 90 days. However, only 27 percent of the evacuees had left the theater by 60 days, and only 54 percent by 90 days. Twenty-eight percent were evacuated after 120 days. By not following a rigorous 120-day evacuation policy the theater gained an additional 8 percent of admissions returned to duty, or 11 percent of the total, but at the price of about 20 percent of the total hospitalization. In other words, the cost of returning the 8 percent to duty after 120 days was almost twice the average cost per patient returned to duty, and more than twice the average cost for those returned prior to 120 days. In view of the small proportion of patients who may be returned to duty after 120 days, and in view of the cost which their continued hospitalization entails, it may be questioned whether an evacuation policy in excess of 120 days is logically sound for any theater. Facilities for evacuation were not always available over the period of observation, and in many cases the attending surgeons did not believe early evacuation to be in the best interest of the patient. The number of cases involved is too small to have exerted any real pressure upon hospital facilities in the Southwest Pacific, but in a more active theater such a schedule of evacuation would have an appreciable influence upon the need for fixed beds.

The significance of body region for speed of recovery, evacuation, and death is shown in the accompanying panels. The data for all regions, shown on the first page, are brought together in the first panel of the second page to illustrate the method of presentation. Each location is then shown separately. Head, face and neck wounds involved a high fatality but also permitted the quickest and greatest return to duty, primarily because such wounds tend to fall into two distinct classes from the standpoint of their gravity. The highest fatality was for abdominal wounds which also had a very high rate of evacuation and the fewest returned to duty by the end of 180 days. For other locations the percentage returned to duty in 180 days varied little within the range of 70 to 76 percent, but for abdominal wounds it was only 55 percent. The rate of evacuation was highest for men with wounds of the upper extremities and nearly as high for men with lower extremity wounds. The status of each type of patient at the end of 180 days is shown graphically below.

STATUS OF SOUTHWEST PACIFIC BATTLE CASUALTIES 180 DAYS AFTER ADMISSION  
BY LOCATION



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## DISEASE AND INJURY

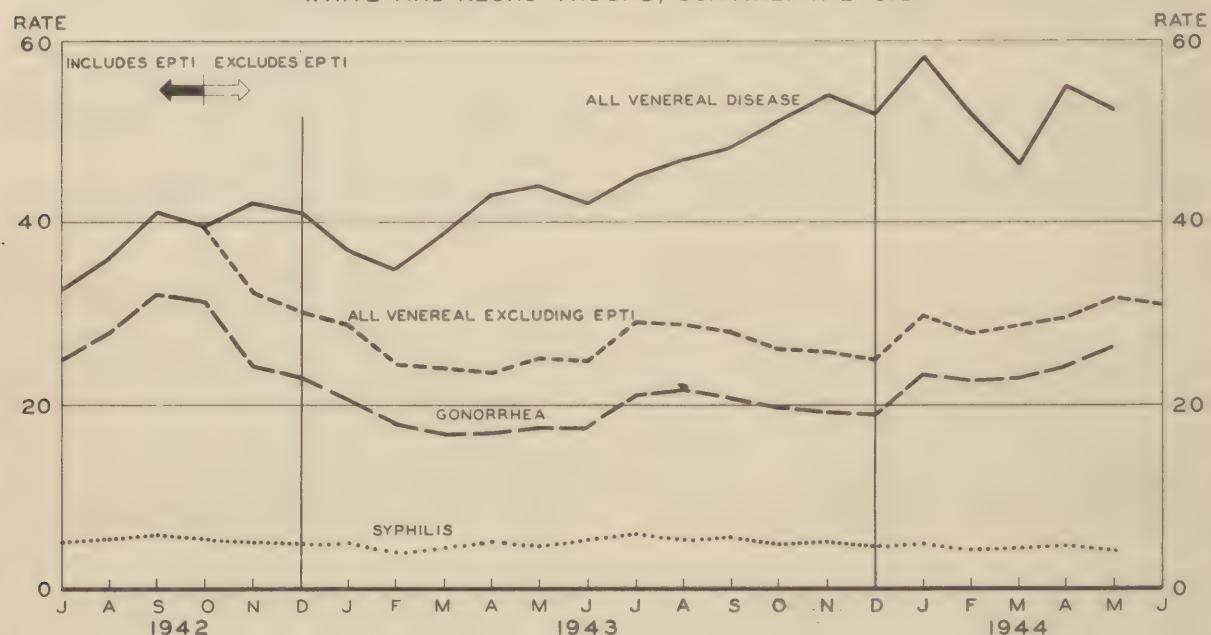
### VENEREAL DISEASE, CONTINENTAL U. S.

If cases contracted prior to induction are included, the admission rate for venereal disease has fluctuated widely since February. The decline during February and March had no parallel in the corrected rates (excluding EPTI) indicating that the decrease occurred in the number of venereally infected men inducted into the Army during that period. The difference may be attributable in large part to the change in induction procedure which occurred in February and to the resulting disturbance in reporting. In April the rate rose to its previous level but there was a slight decline in May.

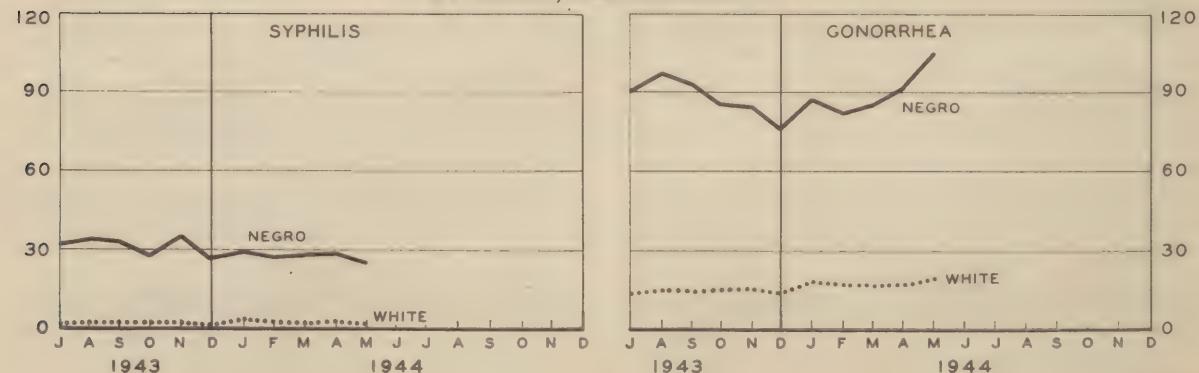
The curve for all venereal disease, corrected to exclude EPTI cases, has moved gradually upward since February. This curve is determined by the gonorrhea admissions, as may be seen from the chart below. Admissions for syphilis have remained relatively stable since last August with a slight downward trend.

The charts at the bottom of the page show rates for syphilis and gonorrhea separately by color. Syphilis rates for both white and Negro troops have declined slightly in the past few months, but the incidence of gonorrhea has increased for both white and Negro troops during the first 5 months of 1944. The Negro rate reached a new high of 104 admissions per thousand men per year in May.

### VENEREAL DISEASE, ADMISSIONS PER THOUSAND MEN PER YEAR WHITE AND NEGRO TROOPS, CONTINENTAL U.S.



### BY COLOR, EXCLUDING EPTI



## DISEASE AND INJURY

### VENEREAL DISEASE IN THE CONTINENTAL U. S. (Continued)

For all posts, camps, and stations having a Negro male strength of 1,000 or more, the venereal disease admission rates have been tabulated and grouped below into broad classes by color and by diagnosis. Each panel gives the average percentage of camps having specified rates during March, April, and May. The small arrows denote the appropriate average U. S. rates for the three months combined. A few camps having inordinately high rates have been excluded from the distributions shown.

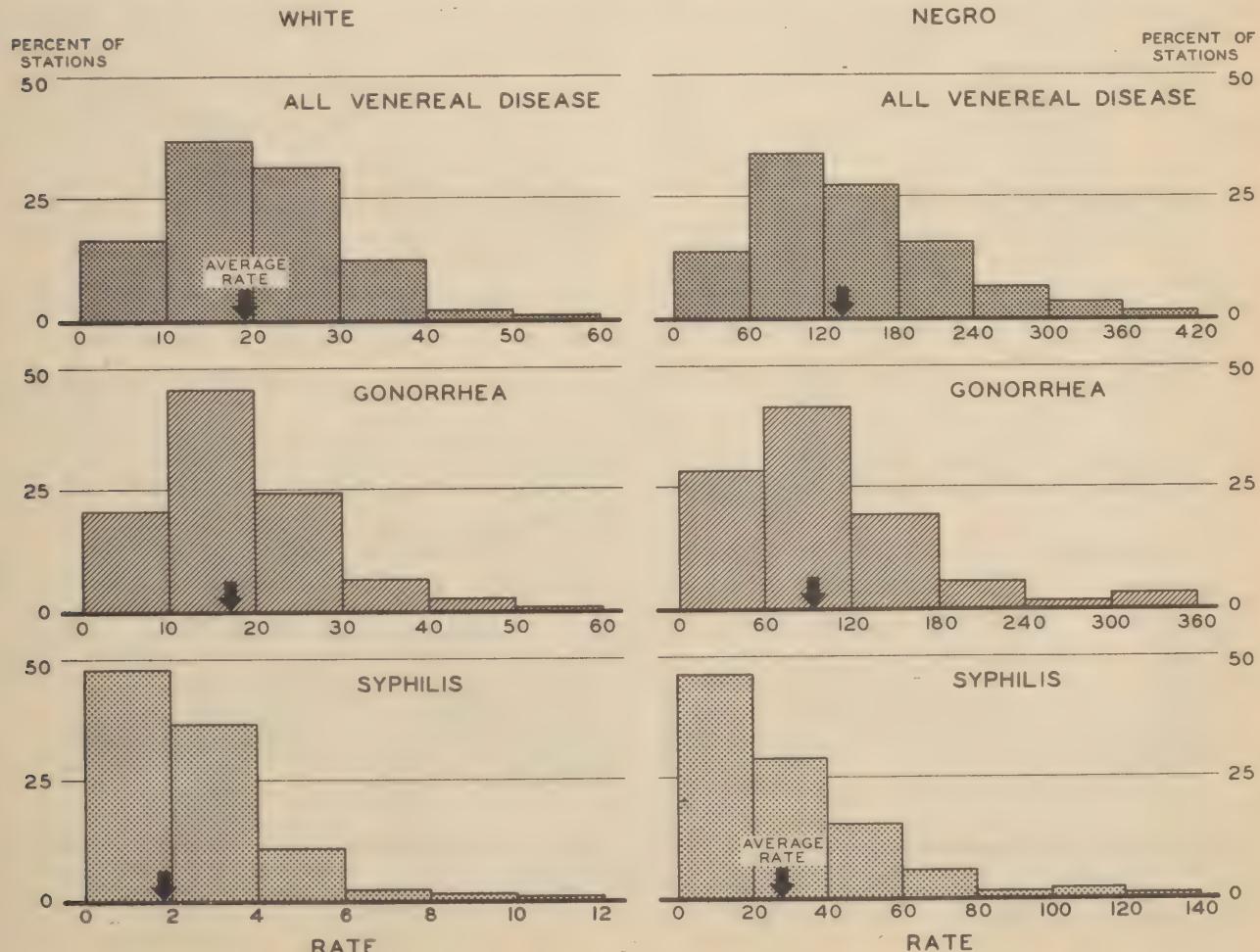
Each distribution shows how widely the camps scatter about the average rate. The white and Negro rates are necessarily drawn to different scales, but the essential similarity in the general form of the distributions is evident. Some of the variation, especially for syphilis, results from the operation of chance factors. The expected numbers of cases of syphilis are so low that for a small camp it is not unusual to have a rate of zero. In both syphilis distributions many of the stations falling within the first interval had no cases.

In forming the distributions below note was made of some of the camps which were consistently high. Apart from ports of embarkation and staging areas, which were often among the highest, the following are the camps which most often go to make up the extreme right-hand portions of the distributions below:

Camp Butner, 4th S. C.  
 Camp Forrest, 4th S. C.  
 Greensboro HTC, 4th S. C.  
 Camp Sutton, 4th S. C.  
 Camp Campbell, 5th S. C.

Jefferson Barracks, 7th S. C.  
 Camp Livingston, 8th S. C.  
 Camp Polk, 8th S. C.  
 Camp Swift, 8th S. C.

### DISTRIBUTION OF STATIONS\* ACCORDING TO VENEREAL DISEASE ADMISSIONS PER 1,000 STRENGTH PER YEAR, MARCH THROUGH MAY, 1944



\* Having a Negro strength of 1,000 or more; EPTI cases are excluded.

## DISEASE AND INJURY

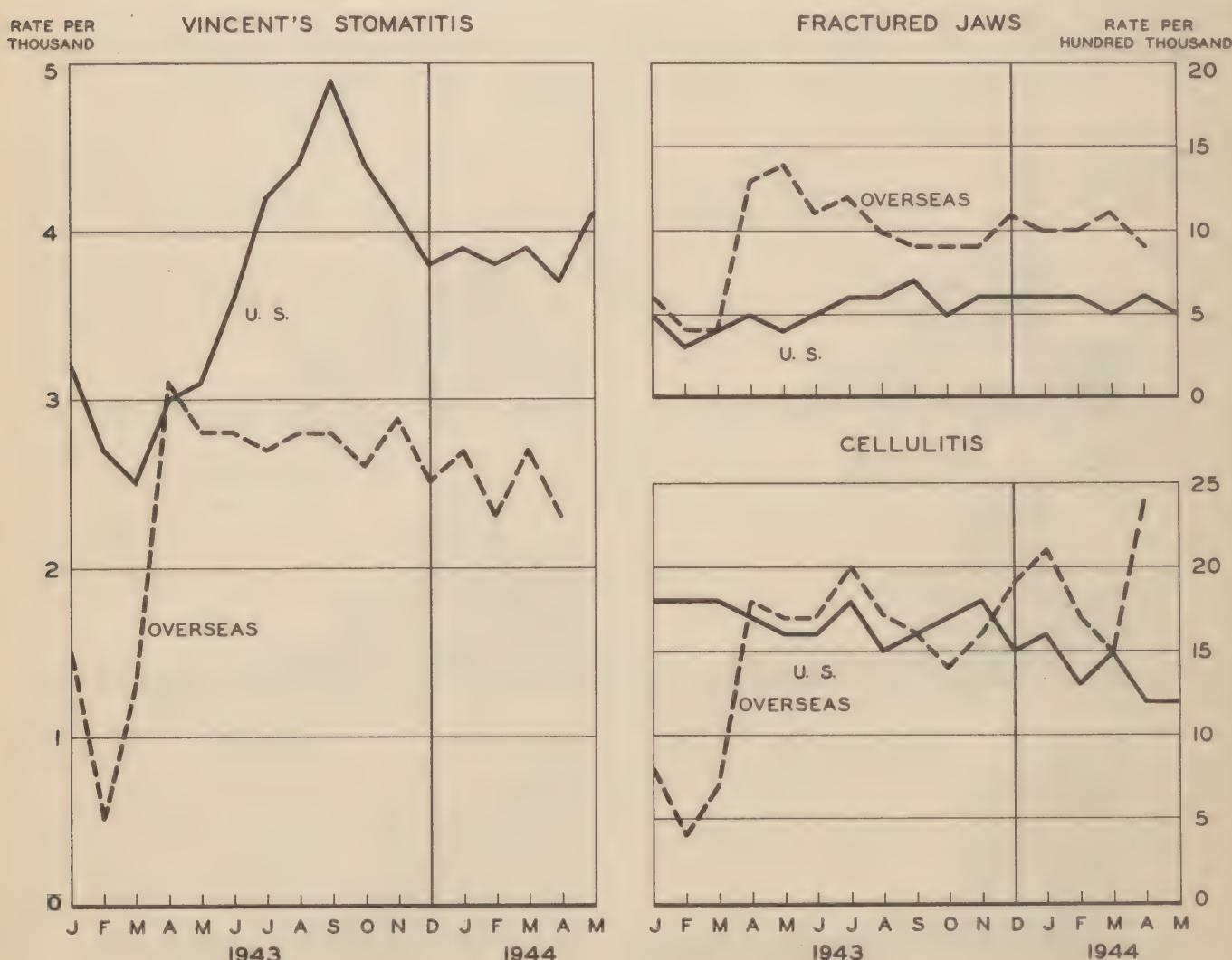
### DENTAL INFECTION AND INJURY

Vincent's Stomatitis has proved to be a less serious problem in this war than predicted, and with one exception the overseas rate has been consistently lower than that for troops in the Continental U. S. The U. S. peak was reached in September of 1943 with an incidence of 4.9 admissions per thousand men per month. The present experience is about 4.0 per thousand men per month in this country, while overseas it is about 2.5. The attack rate for Vincent's Stomatitis is generally higher in areas where troops are in relatively close contact with the civilian population.

Jaw fractures have continued to occur more frequently overseas than in the U. S., the highest rate being that of 14 per hundred thousand overseas troops in May 1943. The rate for the U. S. is a little more than half that for the overseas theaters. Reports indicate that the difference between the two rates results primarily from battle casualties in the combat areas.

Cellulitis, a result of dental infection, has been slightly more frequent among overseas troops during the past year. During April a new high point of 24 per 100,000 men per month was reported for troops overseas. The increase was evident, however, only in the European Theater, where the rate was 39 per 100,000 men per month. There is as yet no explanation for this sharp rise.

### DENTAL ADMISSIONS PER THOUSAND (OR HUNDRED THOUSAND) MEN PER MONTH CONTINENTAL U. S. AND OVERSEAS



## HOSPITALIZATION

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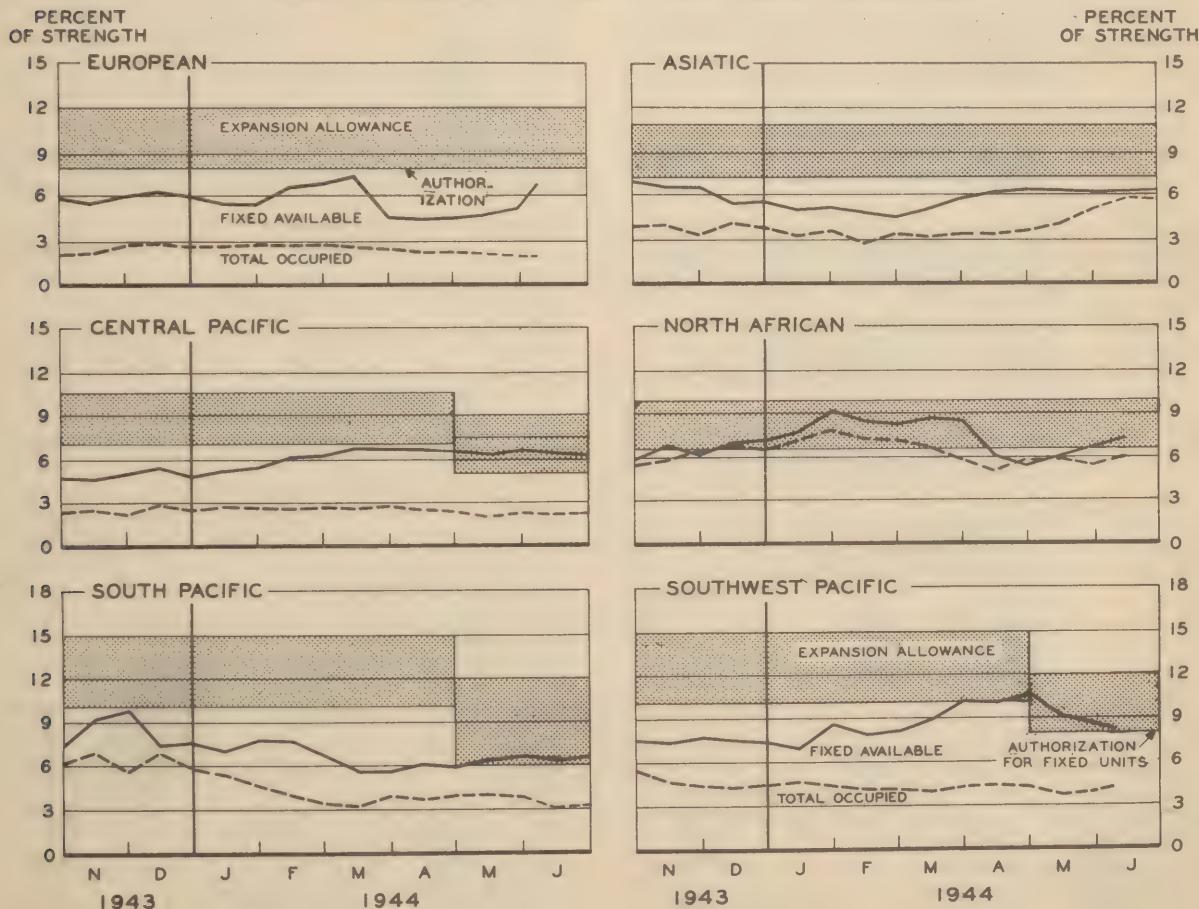
## HOSPITALIZATION OVERSEAS

In comparison with the five percent of U.S. strength currently provided in the U.S. for station plus general hospitals, some overseas theaters require 10 percent or more in beds in fixed hospital units (station, general, and field hospitals). The question of theater hospitalization needs is subject to continued study. Estimates of their requirements must take into consideration not only tactical activity, present and planned, but also the probable incidence of disease and nonbattle injury, facilities for the evacuation of patients needing special treatments or extended periods of hospitalization, the evacuation policy itself, and the presence of prisoners of war and civilians requiring treatment. In the Asiatic Theater, provision is made for hospitalization in support of Chinese units in India which are excluded from the strength.

The authorization levels for fixed bed units are the lower limits of the horizontal shaded bars, and the 50 percent expansion allowances are the upper limits. For the Asiatic Theater, however, the authorization is that set for U.S. troops only. The expansion of bed capacity beyond the T/O capacity necessitates a more intensive utilization of personnel than that intended by the tables of organization except as an emergency measure. The solid line gives, as a percent of strength, the fixed beds (including expansion beds) reported as available by the theater in its weekly telegraphic report. The dotted line shows the total number of hospitalized patients in fixed and mobile hospitals, also as a percent of strength. The comparison between available fixed beds and total occupied beds is made in order to indicate what the fixed hospital load would be were all mobile facilities required to move in support of tactical operations. The points are provisional in that they are based upon telegraphic strengths, which are frequently only approximately correct. The decline in beds available in the Southwest Pacific reflects changes in strength.

Bed occupancy continued to advance in the Asiatic Theater and also rose appreciably in North Africa. The reports from the European Theater have been delayed.

**AUTHORIZATION FOR FIXED BEDS, EXPANSION ALLOWANCE, ALL FIXED  
BEDS AVAILABLE, AND TOTAL BEDS OCCUPIED**



RESTRICTED

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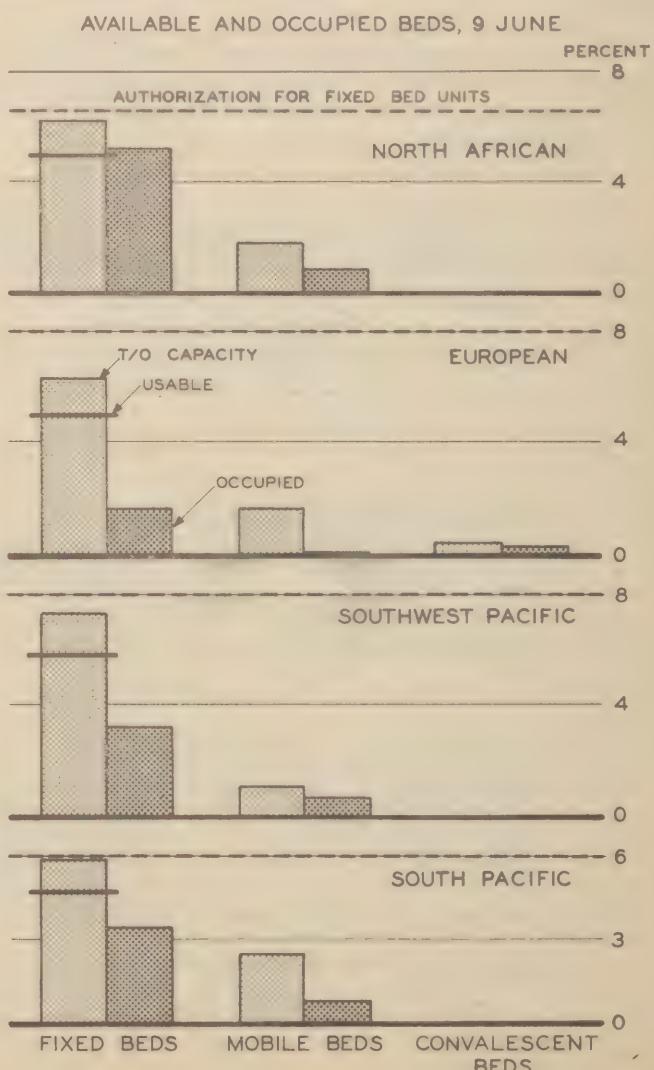
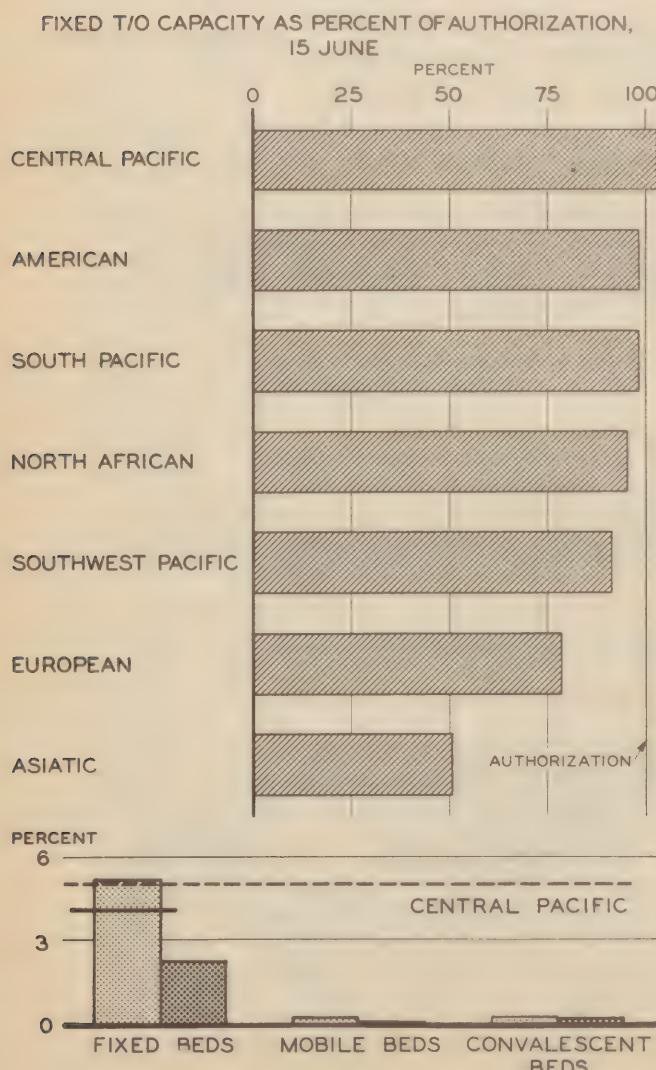
## HOSPITALIZATION

**HOSPITALIZATION OVERSEAS (Continued)**

Recent modifications in reporting make it possible to provide a more complete picture of the hospitalization in each theater. The first chart below permits a comparison of the current WD authorization for fixed bed units with the T/O capacity of fixed bed units reported to be in the theater on 15 June. In most theaters the reported T/O capacity closely approximated the authorized level, but it was less than 80 percent for the European and almost 50 percent for the Asiatic Theater. The WD authorization for fixed hospital beds in the Asiatic Theater includes 4,560 beds (8 percent of ceiling strength of 57,000) for the Chinese Army in India. However, on 9 June the reported strength of the Chinese Army in India was 78,000.

The lower panels summarize the hospital situation in each major theater as reported telegraphically for 9 June 1944. For fixed bed capacity the "usable" line drawn across the bar for fixed T/O capacity shows the 80 percent point of maximum efficient utilization without resort to expansion equipment. In North Africa this point has been exceeded, indicating that expansion facilities are required. In the Asiatic Theater facilities were similarly crowded, and about 80 percent of the mobile beds were occupied on 9 June. An Asiatic panel was not prepared because reports from that theater are not entirely clear as to the availability and utilization of beds on the part of Chinese troops. The small amount of mobile hospitalization in the Central Pacific as compared with other active theaters is attributable to the use of field hospitals in a mobile capacity and to the use of naval facilities in joint operations. Only the Central Pacific, European, and Asiatic theaters reported convalescent beds on 9 June. The convalescent hospital (3000 beds) in the South Pacific Area is reported in the total for mobile beds.

## STATUS OF HOSPITALIZATION, MAJOR THEATERS



ESTMATE

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# HOSPITALIZATION

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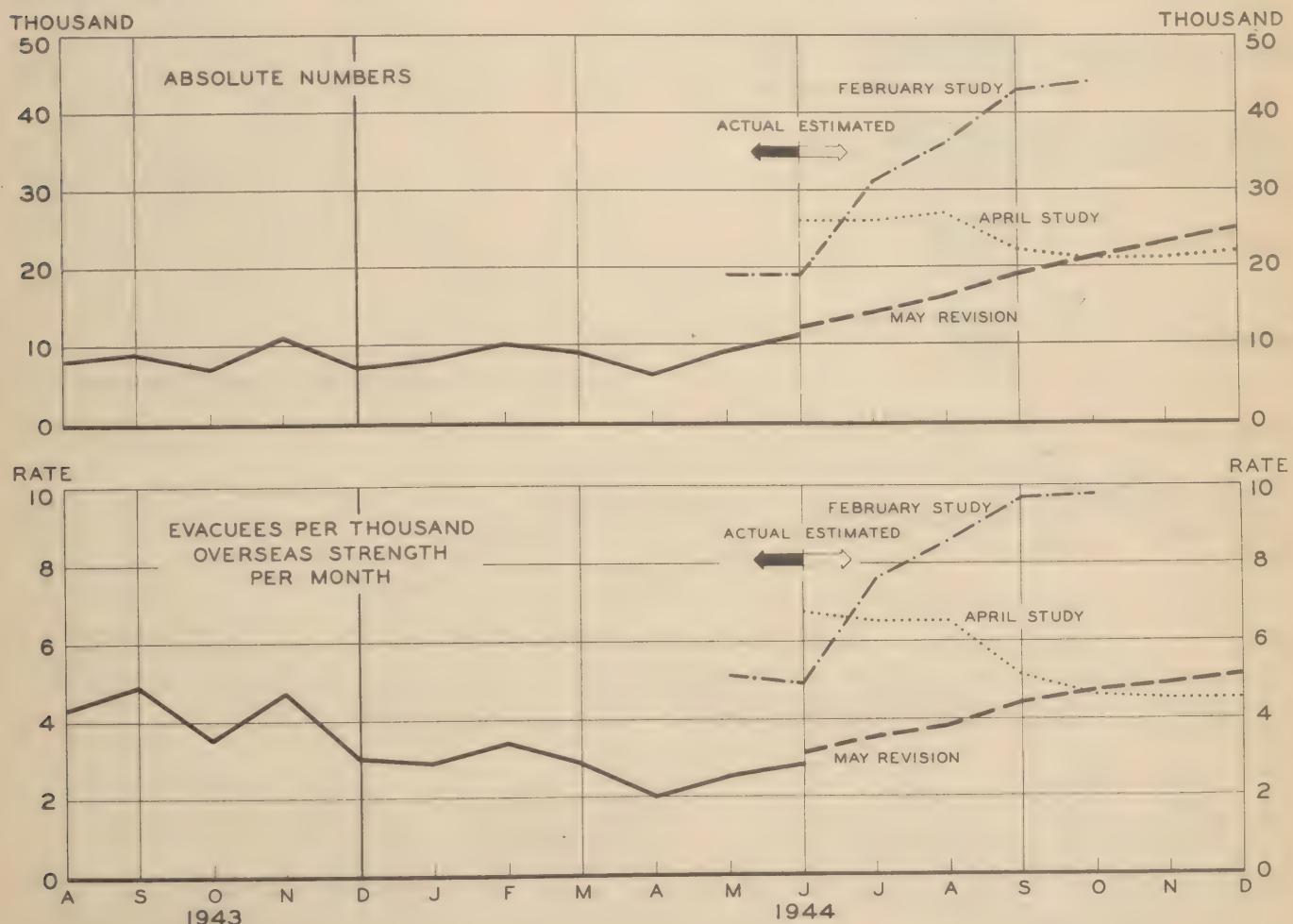
## EVACUATION FROM OVERSEAS

During June there was a slight decline in evacuations by water but a great increase in those by air. The final reports for air evacuation are not yet available, but a rough estimate of twice the May lift is used in the charts below. This brings the preliminary total to about 11,000 patients, a rate of 2.9 per 1,000 overseas strength per month. It had been estimated that about 12,000 would arrive in June. The landing in France and the acceleration of combat activity in North Africa and the Pacific were too recent to have had a very great effect upon the rate of evacuation during June.

The problem of estimating the number of evacuees likely to arrive in the U. S. is rendered difficult by the unreliability attached to long-range casualty estimates. The accompanying charts provide three projections which have guided Medical Department planning in recent months, as described in HEALTH for May 1944.

The three projections provide a range of estimates for the number of overseas patients likely to require hospitalization or convalescent care in the U. S. On the assumption of an average stay of 90 days, the peak load would be the maximum expected in any three consecutive months. In this sense the three curves yield peak loads of 123,000 patients, 80,000 patients, and 70,000 patients, a fairly wide range of estimates. In forecasting the need for hospital beds an additional 25 percent is required for dispersion.

## ACTUAL AND ANTICIPATED EVACUATION OF PATIENTS FROM OVERSEAS



**ESTIMATED**

**SECRET**

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## HOSPITALIZATION

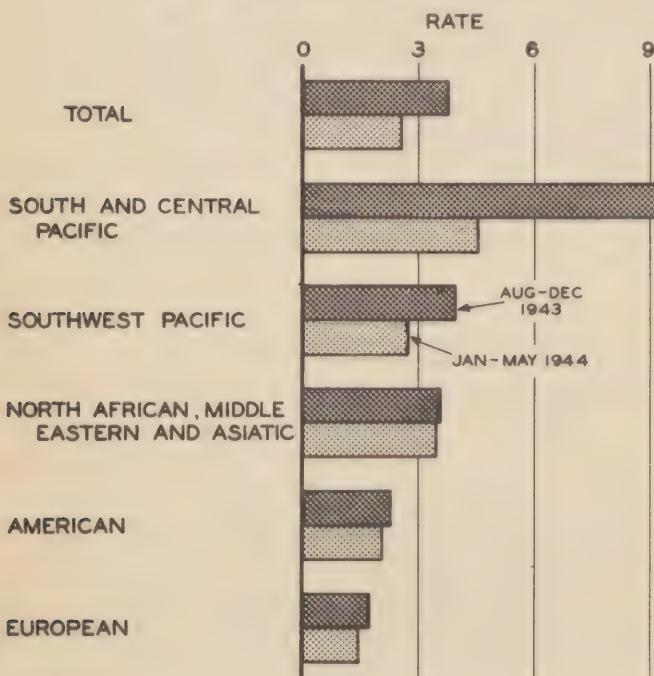
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### EVACUATION FROM OVERSEAS (Continued)

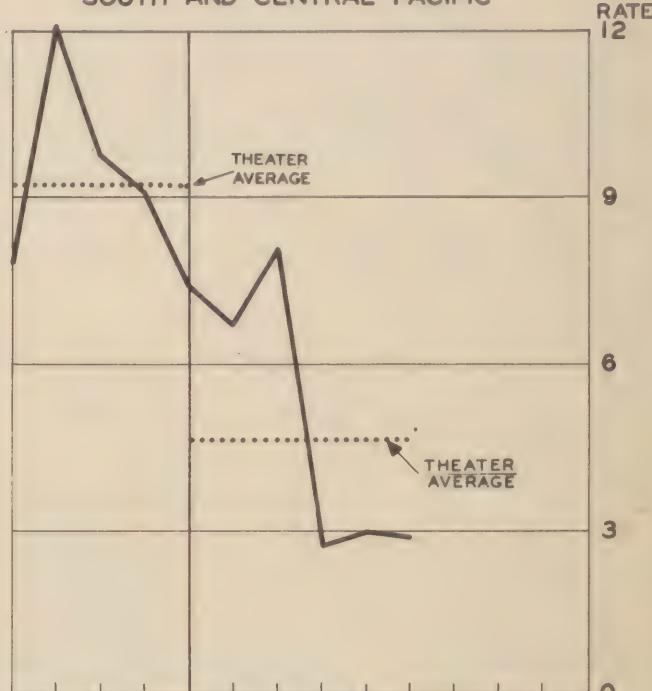
In extension of the data portrayed on the previous page there is shown below the recent evacuation experience of the overseas theaters, the rates being in the form of debarked patients per 1,000 theater strength per month. The horizontal lines on the individual panels give the average theater experience over the period shown, and the theater averages are compared in the first panel below. The Pacific Theater, and especially the South Pacific section, which long maintained a 60-day evacuation policy, has had a considerable effect upon the total overseas rate in the past. However, the rate for this theater has declined fairly steadily since September 1943 to a point where, in March and April, it closely approximated the average rate for all overseas forces.

### EVACUEES PER 1,000 MEN PER MONTH, OVERSEAS THEATERS

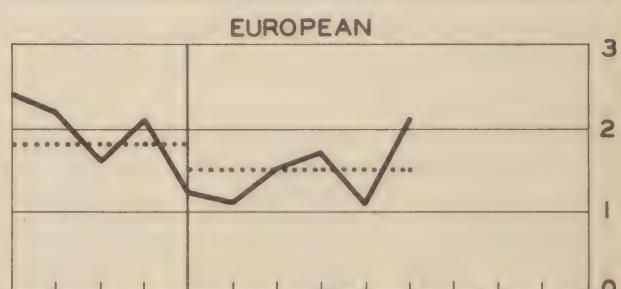
#### AVERAGES-ALL THEATERS



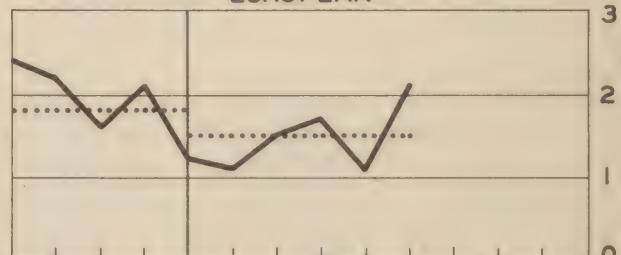
#### SOUTH AND CENTRAL PACIFIC



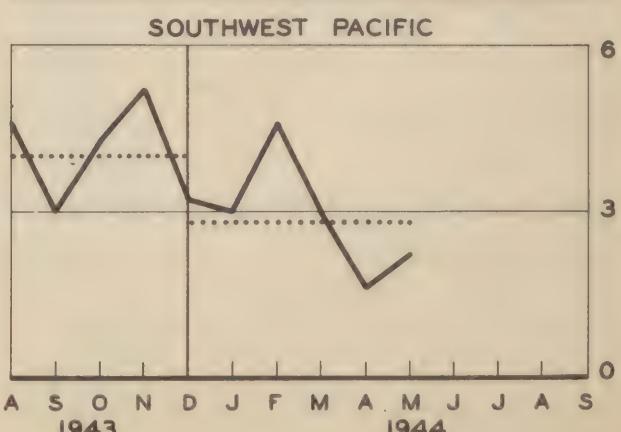
#### AMERICAN



#### EUROPEAN



#### NORTH AFRICAN, MIDDLE EASTERN, ASIATIC



A S O N D J F M A M J J A S

A S O N D J F M A M J J A S

1943

1944

## MORTALITY

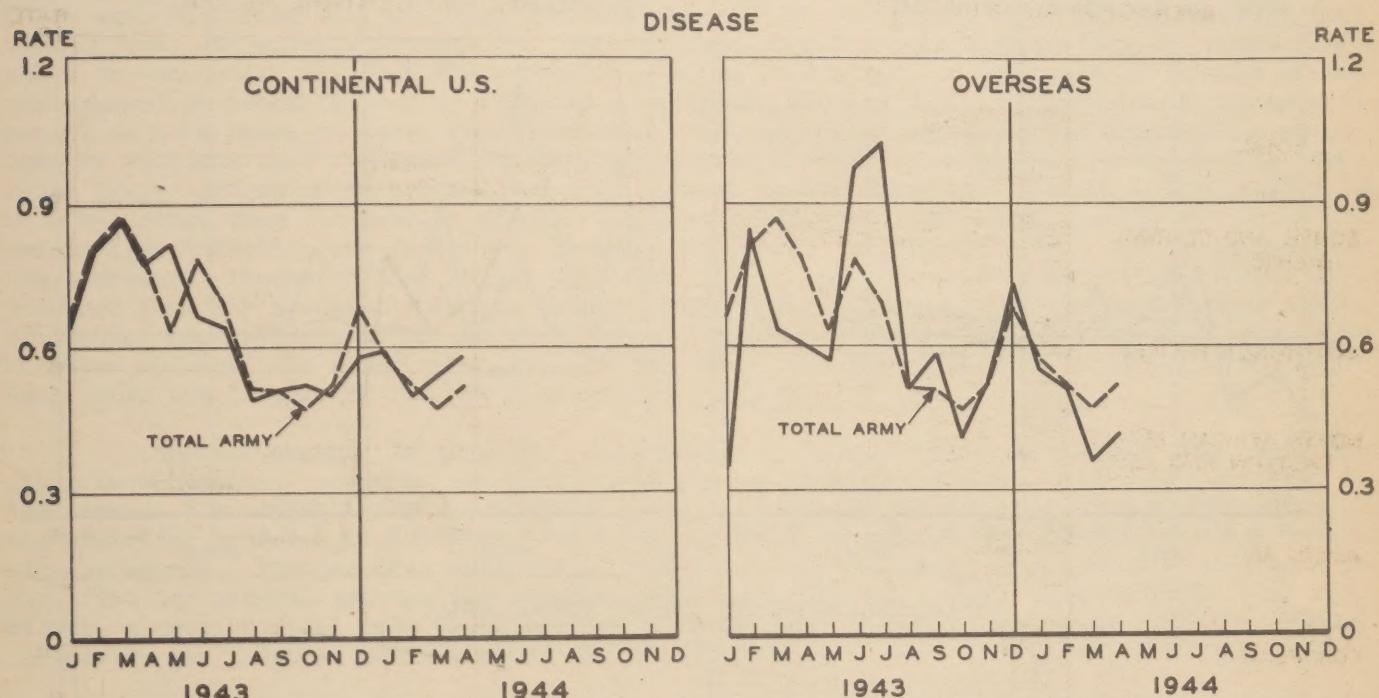
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## MORTALITY FROM DISEASE, NONBATTLE INJURY, AND BATTLE CAUSES

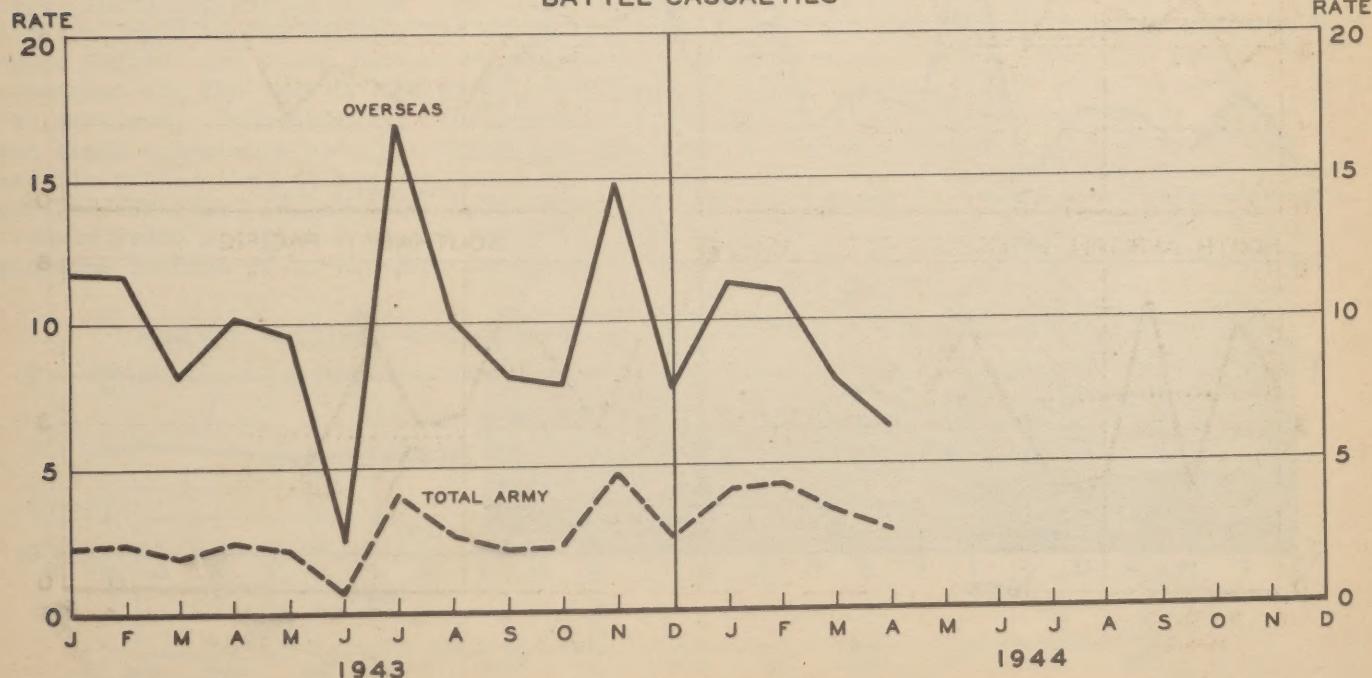
Recent tabulations by The Adjutant General provide the first reasonably accurate counts of deaths from nonbattle injury and from battle causes in terms of the month of occurrence. In the charts below and on the following page the monthly series are shown in the form of deaths per 1,000 men per year. The rates for disease overseas are somewhat higher than those previously reported in *HEALTH* on the basis of reports to The Surgeon General, suggesting some incompleteness in these reports. The peak in June and July 1943 is unexplained at the present time.

The second panel below compares the average battle death rate for troops overseas with that for the entire Army.

DEATHS PER 1,000 MEN PER YEAR, JAN 1943-APR 1944



BATTLE CASUALTIES



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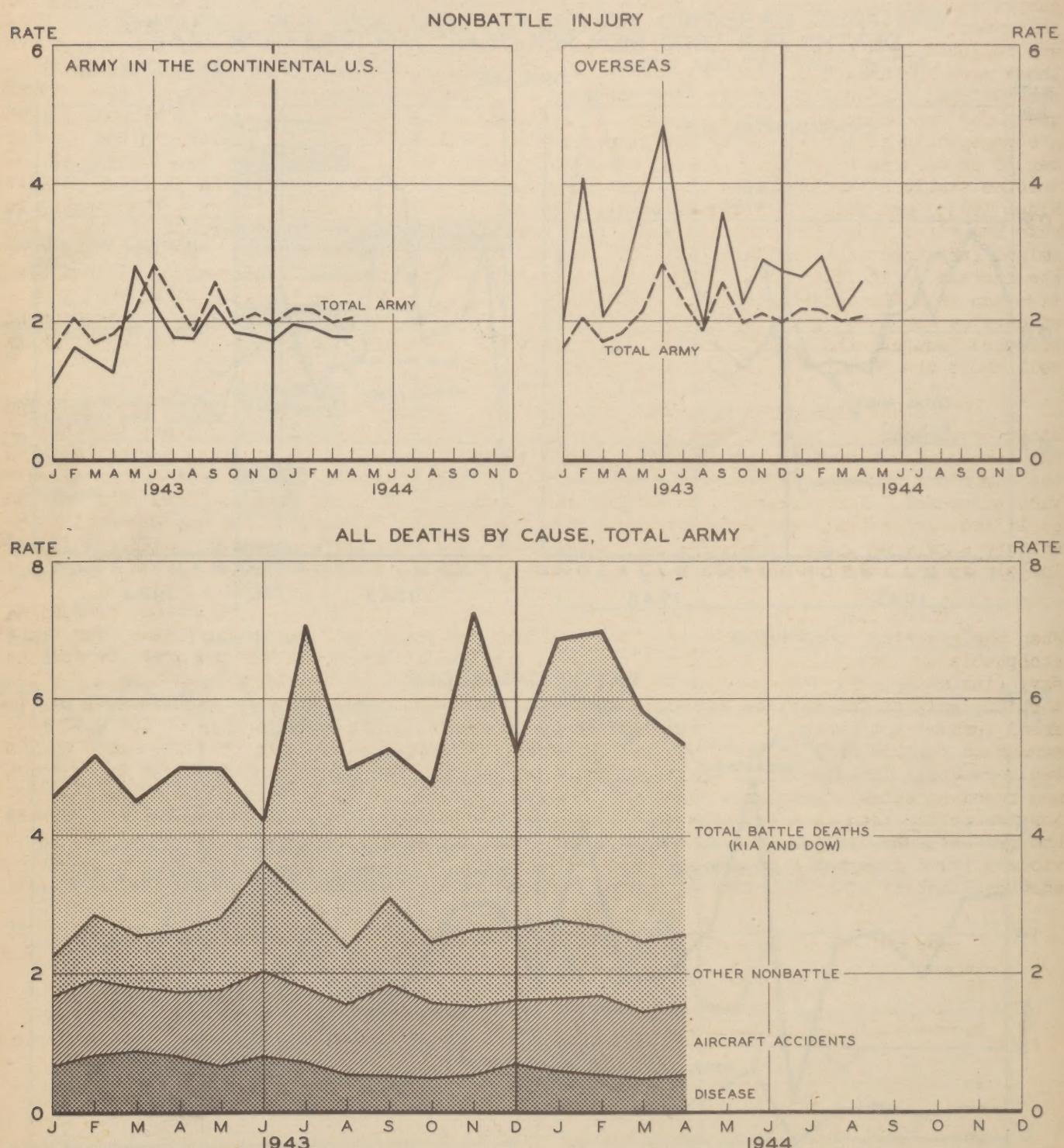
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## MORTALITY

### MORTALITY FROM DISEASE, NONBATTLE INJURY, AND BATTLE CAUSES (Continued)

Death rates from nonbattle injury, including suicide, have fluctuated widely among troops overseas, but at a generally higher level than for troops in the Continental U. S. Deaths from aircraft accidents are not yet available in the AGO tabulations in separate form for the U. S. and overseas. In the bottom chart for the total Army, however, they are shown separately together with the other components of the total death rate. About twice as important as disease, they rank next to battle causes in their contribution to the total death rate.

#### DEATHS PER THOUSAND MEN PER YEAR



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## MISCELLANEOUS

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### CHANGES IN INDUCTION PROCEDURES

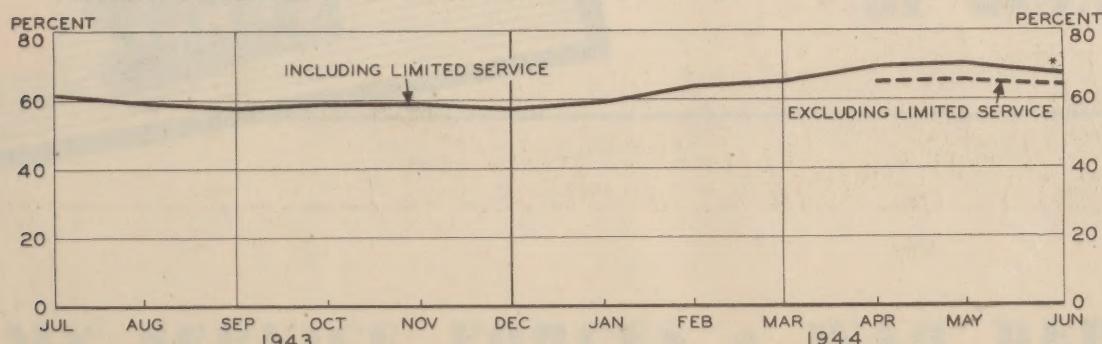
Within the last few months the induction of men into the armed forces has changed in several important respects. The most far-reaching change has been the virtual cessation of the induction of men over 26 years of age. The group of men sent up for induction began to change markedly as far back as the latter part of 1943 when the continuing demands of the armed forces first caused fathers to be called up in substantial numbers. As a result of the call upon fathers the rejection rate, which had been rising throughout the first three quarters of 1943, ceased to increase and leveled off during the last quarter of the year.

Since the latter part of 1943 the emphasis has shifted almost completely from the induction of non-fathers to the induction of young men without regard to fatherhood. This change was brought about largely as a result of the pressing needs of the armed forces for young men. The first step was the elimination of dependency as a cause of deferment. This was followed by a tightening of occupational deferments in the case of younger men, first for those aged 18 through 21, and then for those 18 through 25 years of age. At the present time occupational deferments (except for agricultural workers) are granted only in exceptional cases for men under 26, but are generally granted in the case of men aged 26 through 29 who are engaged in essential war or civilian activities, and are liberally granted in the case of men 30 or more years of age. These changes in the men being forwarded for examination at induction stations are reflected in the increase which has occurred in the acceptance rate since 1943, and which is evident for all classes of disqualifying defects. The acceptance rate has risen from 58 percent during the last quarter of 1943 to 69 percent of those examined (pre-induction and induction) during the second quarter of 1944. So large has been the increase, in fact, that it has more than offset the effect of transferring limited service men from the acceptable to the non-acceptable group. Thus, in recent months, when limited service men have constituted 4 or 5 percent of those examined, their exclusion from those accepted reduces the acceptance rate for the past few months from 69 to 64 percent, still well above the 58 percent for the last quarter of 1943.

Another change in manpower requirements, brought about by current war needs and other developments, concerns men qualified only for limited service. The sharp increase in the demand for combat troops overseas, and the virtual completion of the job of building up the numerical strength of the Army, have correspondingly reduced the demand for limited service personnel. Furthermore, substantial numbers of men evacuated from overseas will not be qualified for general service assignments upon their return to duty. Such evacuees will constitute a growing pool from which men may be drawn for special assignments hitherto filled largely by men inducted under limited service standards.

There have also been significant administrative changes in induction procedure. When the practice of giving pre-induction examinations was started in January 1944, men found acceptable on pre-induction examinations were immediately earmarked for the Army or for the Navy (including Marine Corps and Coast Guard). Such men were available, upon call for induction, only to the service for which they were earmarked. The changing requirements of the armed forces and other factors resulted in the accumulation in many states of pools of men, earmarked for the Army or the Navy, which were disproportionate to the relative needs of the two services. Consequently, the practice of earmarking was discontinued early in June and men found acceptable upon pre-induction examination were simply classified as acceptable for service rather than as acceptable to the Army or to the Navy. The allocation of men between the two services is now left open until the time of induction. The induction of men previously found acceptable on pre-induction examination is again being handled by the induction stations instead of by the Army reception centers and Navy recruiting stations respectively.

PERCENT ACCEPTED AMONG REGISTRANTS EXAMINED AT INDUCTION CENTERS



\* Induction of limited service men was suspended on 1 June 1944.

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